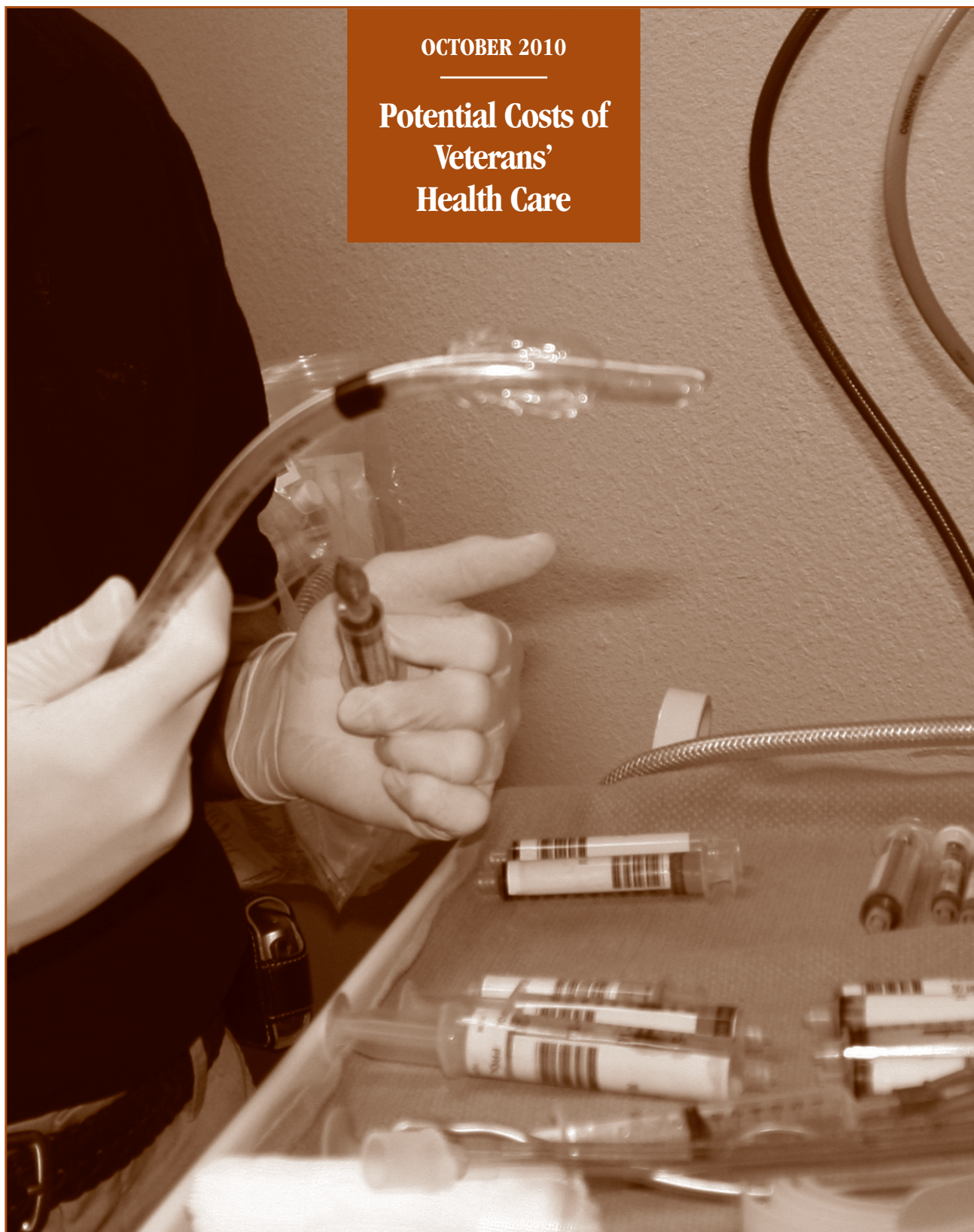


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CONGRESSIONAL BUDGET OFFICE

A
CBO
REPORT

OCTOBER 2010

Potential Costs of
Veterans'
Health Care



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Potential Costs of Veterans' Health Care

October 2010

Notes

Unless otherwise indicated, all years referred to in this report are federal fiscal years (which run from October 1 to September 30), and all dollar amounts are expressed in 2010 dollars (having been converted, when necessary, using the gross domestic product price index).

Numbers in the text and tables may not add up to totals because of rounding.



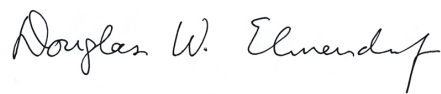
Preface

The Department of Veterans Affairs (VA) is operating its medical care system and associated research program with a budget of \$48 billion for 2010, a rise of 8 percent in nominal terms (without adjusting for inflation) from 2009. In nominal terms, that budget grew at an average rate exceeding 9 percent annually between 2004 and 2009. VA's health care budget will face continued pressure over the next few years: Additional veterans are likely to seek care from VA, and cost increases in medical care are expected to continue to outpace cost increases for other goods and services.

This Congressional Budget Office (CBO) report—which was mandated by section 104 of the Consolidated Appropriations Act, 2008 (Public Law 110-161)—examines prospective demands on VA's health care system and the potential budgetary implications of meeting veterans' health care needs over the 2011–2020 period. CBO projects the potential costs to treat all veterans enrolled in VA's health care system and also, separately, projects the potential costs to treat veterans returning from the military operations in Iraq and Afghanistan and related activities. In keeping with CBO's mandate to provide objective analysis, this report makes no recommendations.

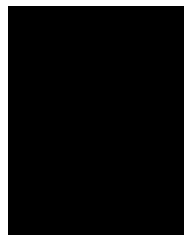
The report was prepared by Heidi Golding of CBO's National Security Division under the supervision of Matthew Goldberg and David Mosher. Nabeel Alsalam, Elizabeth Bass, Sunita D'Monte, Sarah Jennings, and Allison Percy of CBO provided thoughtful comments on earlier drafts, as did Kristy Piccinini (formerly of CBO) and David Hunter of the Institute for Defense Analyses. (The assistance of external reviewers implies no responsibility for the final product, which rests solely with CBO.) Alec Johnson provided research assistance. The Department of Veterans Affairs and the Department of Defense provided data used in the analysis.

Sherry Snyder edited the report, and Chris Howlett and Kate Kelly proofread it. Cindy Cleveland produced drafts of the manuscript. Maureen Costantino prepared the report for publication, with assistance from Jeanine Rees, and designed the cover. Monte Ruffin printed the initial copies, Linda Schimmel handled the print distribution, and Simone Thomas prepared the electronic version for CBO's Web site (www.cbo.gov).



Douglas W. Elmendorf
Director

October 2010



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Summary

The Department of Veterans Affairs (VA) provides health care at little or no charge to more than 5 million veterans annually. Medical services are provided through the inpatient and outpatient facilities run by the Veterans Health Administration. Those services include routine health assessments, readjustment counseling, surgery, hospitalization, and nursing home care.

The Congressional Budget Office (CBO) projects that the future costs for VA to treat enrolled veterans will be substantially higher (in inflation-adjusted dollars) than recent appropriations for that purpose, partly because more veterans are likely to seek care in the VA system but mostly because health care costs per enrolled veteran are projected to increase faster than the overall price level. Under two scenarios that CBO examined, the total real resources (in 2010 dollars) necessary to provide health care services to all veterans who seek treatment at VA would range from \$69 billion to \$85 billion in 2020, representing cumulative increases of roughly 45 percent to 75 percent since 2010.

Although veterans from recent conflicts will represent a fast-growing share of enrollments in VA health care over the next decade, the share of VA's resources devoted to the care of those veterans is projected to remain small through 2020, in part because they are younger and healthier than other veterans served by VA.

Background

To provide health care services, VA depends on discretionary funding that the Congress provides in annual appropriation acts. Although eligibility for VA health care is based primarily on veterans' military service, VA may, and does, adjust enrollment according to the resources available to it.

The Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104-262, 110 Stat. 3177) mandated that VA deliver services to veterans who have service-connected conditions, to veterans unable to pay for necessary medical care, and to specific groups of veterans, such as former prisoners of war. The legislation permitted VA to offer services to all other veterans to the extent that resources and facilities were available; it also required VA to develop and implement an enrollment system to facilitate the management and delivery of health care services.

VA's enrollment system includes eight categories that determine veterans' eligibility and priority for access to health care. The highest priority is given to veterans who have service-connected disabilities (priority groups 1 through 3, or P1 through P3); the lowest priority is given to higher-income veterans who have no compensable service-connected disabilities, that is, no conditions that are disabling to the degree that VA provides compensation (P8).

The number of veterans treated by VA climbed rapidly following the enactment of the 1996 law, increasing from 2.9 million in fiscal year 1995 to 4.5 million in 2003.¹ By 2003, VA no longer had the capacity to adequately serve all current enrollees, prompting the Secretary of Veterans Affairs to suspend further enrollment of some higher-income veterans (those in P8); VA eased that restriction in 2009 to allow some of those veterans to enroll. (Enrolled veterans typically have more than one source of health care available to them and choose to use VA for only a small portion of their health care, relying on other sources such as Medicare, employer-sponsored insurance, or the Department of Defense's TRICARE program.)

1. Some enrolled veterans do not seek treatment from VA each year and consequently are not included in the counts of patients in a given year.

Current Resources

A total of \$44 billion was appropriated to VA for 2009 to provide medical services to veterans and to conduct medical research.² That amount was increased by 8 percent, to \$48 billion, for 2010. VA has requested an appropriation of \$52 billion, an additional 8 percent, for 2011.³ The average annual increase was more than 9 percent from 2004 through 2009.

One group of veterans—those who have deployed or will deploy to overseas contingency operations (OCO), which include Operation Iraqi Freedom, Operation New Dawn, and Operation Enduring Freedom in Afghanistan and related activities—are of particular interest as policy-makers and others attempt to determine the extent of the war-related medical conditions of those veterans and the resources required to treat them. Those veterans accounted for only about 6 percent of all patients in 2009 and 3 percent of the total dollars obligated for veterans'

2. All dollar amounts in this and the following paragraph are reported in nominal terms.

VA's budget for medical care and research includes funding from all of VA's health care accounts, including all collections (that is, reimbursements to VA from third parties for medical care), but excludes funding for construction of medical facilities. In 2009, appropriations for construction totaled more than \$1.5 billion. Funding for medical care and research for 2009 includes \$1 billion appropriated in the American Recovery and Reinvestment Act of 2009 (Public Law 111-5).

3. The Veterans Health Care Budget Reform and Transparency Act of 2009 (P.L. 111-81) authorized advance appropriations for VA's medical services, medical support and compliance, and medical facilities accounts; it also requires that VA's annual budget submission include estimates of appropriations for those accounts for the fiscal year following the budget year. An advance appropriation is an appropriation that first becomes available for the government to obligate (that is, legally commit to pay for goods and services ordered or received) in a fiscal year after the budget year. For example, the Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2010—Division E of the Consolidated Appropriations Act, 2010 (P.L. 111-117)—provided an advance appropriation of \$48 billion for the three health care accounts (excluding the authority to spend collections) to be first available for obligation in fiscal year 2011. The President's budget for fiscal year 2011 (submitted in February 2010) contains the amounts that were appropriated in advance in P.L. 111-117 for the three VA health care accounts and requests additional amounts for medical and prosthetic research and for the spending of collections. Accordingly, the total amount available for VA medical care and research in 2011 will include the advance appropriations made in 2010 modified by funding provided in the appropriation act for 2011.

health care in that year. Of the \$43 billion obligated in 2009, VA estimates that it obligated \$1.5 billion to care for OCO veterans. VA further estimates that those obligations will rise to \$2.0 billion in 2010, \$2.6 billion in 2011, and \$3.3 billion in 2012.

Projecting Future Costs

This CBO report examines prospective demands on VA and projects the resources the agency would need to provide medical care to all enrolled veterans during the next 10 years, 2011–2020. (The report does not attempt to predict appropriations for VA.) Although the focus of this report is on the resources VA would need to treat all enrolled veterans, CBO has also separately projected the portion of those resources that would be needed to treat the veterans of the ongoing overseas contingency operations.

The recent increases in VA's medical budget have reflected factors that will probably affect future resource requirements. First, as is true for all U.S. health care, VA's medical expenditures per enrollee have grown more rapidly than has the overall price level. Second, the ongoing deployments to combat operations in Iraq and Afghanistan have increased the number of veterans seeking care from VA. Third, VA has been easing restrictions on enrolling higher-income veterans (those in P8), in part because of concerns expressed by policymakers and others who believe that restrictions on enrollment have caused some veterans to be denied benefits that they deserve.

To account for some possible policy changes and for uncertainty about the number of veterans who will be enrolled and the growth of medical expenditures per enrollee, CBO presents two scenarios to capture some of the range of possible outcomes. The scenarios differ in their assumptions about the number of enrollees in the VA health care system and the costs of providing medical services (see Summary Table 1). CBO also assumes that there will be no major changes in VA's policies (except for a possible change in eligibility criteria) and that the enrollment of non-OCO veterans (except for higher-income veterans) and the percentage of total health care that veterans receive from VA as opposed to other sources, referred to as their "reliance on VA," follow current trends.

Scenario 1. The first scenario was crafted using assumptions about enrollment and medical expenditures per

Summary Table 1.**Assumptions Underlying the Scenarios Used to Project Enrollment of Veterans and the Potential Costs for VA to Provide Health Care Services to Them**

	Baseline	Scenario 1	Scenario 2
Assumptions Underlying the Scenarios			
Eligibility to Enroll for VA Health Care			
Veterans of overseas contingency operations	n.a.	Deployed troop strength for those operations drops to 30,000 by 2013	Deployed troop strength for those operations drops more slowly, to 60,000 by 2015
All other veterans	n.a.	Policies in place at the beginning of 2010 remain in effect	Enrollment allowed for veterans whose income exceeds thresholds by 30 percent or less; all other VA policies in place at the beginning of 2010 remain in effect
Per Capita Growth in Medical Expenditures	n.a.	About the same rate as in the general population ^a	30 percent faster than in Scenario 1
Projections for All Enrolled Veterans			
Number of Enrollees (Millions)			
2011	n.a.	8.5	8.7
2020	n.a.	8.7	9.3
Potential VA Health Care Costs (Billions of 2010 dollars)			
2011	51	50	52
2016	54	62	70
2020	56	69	85
2011–2020	535	602	682
Projections for Enrolled Veterans of Overseas Contingency Operations			
Number of Enrollees			
In millions			
2011	n.a.	0.8	0.8
2020	n.a.	1.4	1.7
As a percentage of all enrolled veterans			
2011	n.a.	9	9
2020	n.a.	16	18
Potential VA Health Care Costs			
In billions of 2010 dollars			
2011	n.a.	2	3
2016	n.a.	4	6
2020	n.a.	5	8
2011–2020	n.a.	40	54
As a percentage of the potential costs for all enrolled veterans			
2011	n.a.	5	5
2016	n.a.	7	8
2020	n.a.	8	10
2011–2020	n.a.	7	8

Source: Congressional Budget Office.

Notes: The starting point for the cost projections in the two scenarios is the Department of Veterans Affairs' (VA's) appropriation for medical care and research in 2010. CBO's baseline budget projection, following Congressional rules, is based on VA's enacted advance appropriations for 2011 for medical services, medical support and compliance, and medical facilities and on VA's enacted appropriations for 2010 for all other medical accounts. Under those rules, CBO projects baseline spending in subsequent years by adjusting those appropriations by a forecast of future inflation—a weighted average of the gross domestic product (GDP) price index and the employment cost index for wages and salaries. For comparison with the two scenarios, those projections are converted to 2010 dollars by applying the GDP price index. Because CBO projects that wages and salaries will rise more rapidly than the GDP price index, the baseline projection increases slightly (in 2010 dollars) during the 2011–2020 period.

Overseas contingency operations include current military operations in Iraq and Afghanistan and related activities.

n.a. = not applicable.

- a. Projections of growth in medical expenditures for the general population are based on data from the Centers for Medicare and Medicaid Services and others.

enrollee that generate lower resource requirements than Scenario 2. The assumptions about factors affecting enrollment include the following:

- VA's eligibility, cost-sharing, and other policies are those in effect at the beginning of 2010. Those policies include the easing of enrollment restrictions that began in 2009 for veterans in priority group 8 who have no compensable service-connected disabilities and whose income is 10 percent or less above VA's income thresholds.
- The number of troops deployed to overseas contingency operations, which currently include the military operations in Iraq and Afghanistan and related activities, drops to 30,000 by 2013 and remains at that number throughout the decade.
- VA's medical expenditures per enrollee for each priority group grow in nominal terms at slightly more than 5 percent per year, about the same rate as that anticipated in the general population over the decade.

Scenario 2. CBO crafted the second scenario to illustrate potential policy changes and other outcomes that may result in higher resource needs for VA's health care services. The assumptions for that scenario are as follows:

- VA changes its eligibility rules to allow veterans who have no compensable service-connected disabilities and whose income is 30 percent or less above VA's income thresholds to enroll. Other than that change, all policies relating to eligibility, cost sharing, and other factors are those in effect at the beginning of 2010.
- The number of troops deployed to overseas contingency operations declines more slowly than in Scenario 1, dropping to 60,000 by 2015 and remaining at that number through the rest of the decade.
- VA's medical expenditures per enrollee for each priority group grow initially at the rate VA assumed in preparing the Administration's 2011 budget request that was transmitted in February 2010 and, in subsequent years, at an annual rate that is about 30 percent higher than that anticipated in the general population—a rate that exceeds the average rate experienced by VA from 2003 through 2007, before significant

numbers of veterans from the ongoing conflicts had enrolled.

Potential Costs to Treat All VA Enrollees

Under Scenario 1, CBO estimates that total enrollment would grow from 8.0 million in 2009 to more than 8.8 million by 2016—an increase of about 10 percent—but would edge down to 8.7 million in 2020 (see Summary Table 1 and Summary Figure 1). The resources required to treat all enrolled veterans would be about \$69 billion in 2020, nearly 45 percent higher than the \$48 billion that has been provided for 2010.

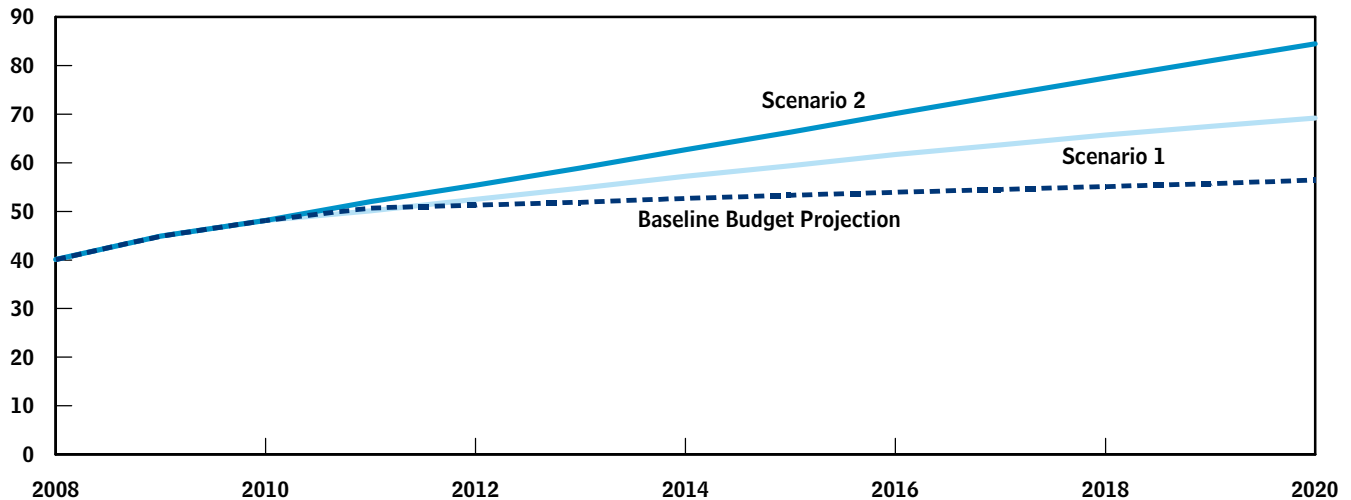
Under Scenario 2, enrollment would be 620,000 higher in 2020 than in Scenario 1, with 340,000 new enrollees resulting from VA's further relaxation of the restrictions on enrollment and 280,000 from the higher troop deployments. The resources required to treat all enrolled veterans would reach nearly \$85 billion in 2020, or 22 percent more than under Scenario 1 and about 75 percent more than the amount provided for 2010.

What factors explain the difference of roughly \$15 billion in the potential costs of the two scenarios in 2020? The disparity between the growth rates of medical expenditures per enrollee in the two scenarios accounts for the lion's share of the difference—\$13 billion. Extending eligibility to additional higher-income veterans who have no compensable service-connected disabilities would add just \$1 billion to the costs under Scenario 1; because those new enrollees are drawn from a group that historically has cost less to treat than most other veterans, the additional resources VA would require would be relatively small. The higher troop levels for contingency operations under Scenario 2 would also add \$1 billion; the increase in the number of enrollees would be small—only about 3 percent—and they too would use fewer resources than the average enrollee.

The projections for both scenarios exceed the baseline projections that CBO constructs in accordance with the provisions set forth in the (now expired) Balanced Budget and Emergency Deficit Control Act of 1985. The baseline projections reflect the assumption that appropriations increase at the same rate as the employment cost index for the wage and salary component of VA's budget

Summary Figure 1.**Potential Costs for VA to Provide Health Care Services to Enrolled Veterans**

(Billions of 2010 dollars)



Source: Congressional Budget Office.

Notes: The starting point for the projections in the two scenarios is the Department of Veterans Affairs' (VA's) appropriation for medical care and research in 2010. CBO's baseline budget projection, following Congressional rules, is based on VA's enacted advance appropriations for 2011 for medical services, medical support and compliance, and medical facilities and on VA's enacted appropriations for 2010 for all other medical accounts. Under those rules, CBO projects baseline spending in subsequent years by adjusting those appropriations by a forecast of future inflation—a weighted average of the gross domestic product (GDP) price index and the employment cost index for wages and salaries. For comparison with the two scenarios, those projections are converted to 2010 dollars by applying the GDP price index. Because CBO projects that wages and salaries will rise more rapidly than the GDP price index, the baseline projection increases slightly (in 2010 dollars) during the 2011–2020 period.

Compared with Scenario 1, under Scenario 2 CBO assumes higher enrollment of veterans of overseas contingency operations (currently including military operations in Iraq and Afghanistan and related activities), further easing of the restrictions on enrollment of higher-income veterans, and faster growth in medical expenditures per enrollee. See the text for a detailed explanation of the scenarios.

and at the same rate as the gross domestic product price index for all other components.⁴

In making its projections, CBO did not explicitly account for recently enacted health care legislation—in particular, the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Although there is considerable uncertainty regarding how the new legislation will be implemented, CBO conducted a

preliminary analysis of how it might affect VA's resource requirements. That analysis indicates that the new laws may either increase or decrease the number of enrollees—and therefore VA's resource requirements—but in either case probably by only a small amount. On the one hand, the costs of obtaining health insurance will be lower for some veterans in the latter part of the coming decade, leading some of them to seek less care from VA than they would have without the recent legislation. On the other hand, to avoid financial penalties that may be assessed on people who do not have a required level of health insurance, some veterans who would otherwise neither enroll in VA's program nor obtain other insurance might choose to enroll with VA. Neither of those effects is likely to be large enough to significantly affect the projections in this report.

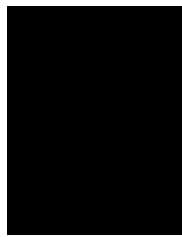
4. The projections shown in this report are from CBO's January 2010 report *The Budget and Economic Outlook: Fiscal Years 2010 to 2020*. CBO recently released *The Budget and Economic Outlook: An Update* (August 2010), which updates CBO's baseline budget and economic projections. Those economic projections, however, are not sufficiently different from the ones in the January volume to affect the projections for VA presented in this report.

Potential Costs to Treat Veterans of Overseas Contingency Operations

As part of its projections for the resources needed to treat all enrolled veterans, CBO separately estimated the portion of resources that would be required to treat veterans of overseas contingency operations. CBO estimates that between the time hostilities began and the end of 2020, VA would enroll a total of 1.4 million or 1.7 million OCO veterans under Scenarios 1 and 2, respectively.⁵ The annual resources (in 2010 dollars) required to treat

OCO veterans would increase from an estimated \$2.0 billion in 2010 to \$5.4 billion in 2020 under Scenario 1 and to \$8.3 billion under Scenario 2. Because OCO veterans are typically younger and healthier than the average VA enrollee, they are less expensive to treat. Accordingly, the resources devoted to OCO veterans would be a small share of outlays, consuming 8 percent and 10 percent of VA's resources for health care services in 2020 under Scenario 1 and Scenario 2, respectively. As the OCO veterans age, however, CBO expects that their costs will be similar to those of other older veterans who use VA's health care services.

5. Operations in Afghanistan and Iraq began in October 2001 and March 2003, respectively.



Potential Costs of Veterans' Health Care

Introduction

Providing health care services to military veterans is an important part of the Department of Veterans Affairs' (VA's) mission. Veterans usually receive those services at facilities operated and staffed by the Veterans Health Administration (VHA), which also conducts medical research. To carry out its medical mission, VA relies on annual appropriations (unlike Medicare, for example, which is funded by permanent appropriations). The Congress appropriated \$44 billion for that mission in 2009 and \$48 billion (8 percent more) in 2010. VA has requested an appropriation of \$52 billion, an additional 8 percent, for 2011.¹

VA's medical expenditures per enrollee, like medical expenditures per capita in the U.S. population, are growing faster than general inflation. In addition, the number of veterans seeking care at VA has increased in recent years and will probably continue to increase over the next few years.

This Congressional Budget Office (CBO) report examines future demands on VA's health care system and the resources it would require to meet those demands over the 2011–2020 period. CBO projects the potential costs of treating all enrolled veterans under two scenarios with different assumptions about eligibility for enrollment and the growth of health care expenditures per enrollee. The projections for both scenarios exceed the baseline projections that CBO constructs in accordance with the provisions set forth in the (now expired) Balanced Budget and Emergency Deficit Control Act of 1985. The baseline projections reflect the assumption that appropriations increase at the same rate as the employment cost index for the wage and salary component of VA's budget

and the gross domestic product price index for all other components.²

Along with its projections of resources required to treat all veterans, CBO presents additional detail on the projected resources required to treat veterans of overseas

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1. All dollar amounts in this paragraph are reported in nominal terms.

The Veterans Health Care Budget Reform and Transparency Act of 2009 (Public Law 111-81) authorized advance appropriations for VA's medical services, medical support and compliance, and medical facilities accounts; it also requires that VA's annual budget submission include estimates of appropriations for those accounts for the fiscal year following the budget year. An advance appropriation is an appropriation that first becomes available for the government to obligate (that is, legally commit to pay for goods and services ordered or received) in a fiscal year after the budget year. For example, the Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2010—Division E of the Consolidated Appropriations Act, 2010 (P.L. 111-117)—provided an advance appropriation of \$48 billion for the three health care accounts (excluding the authority to spend collections) to be first available for obligation in fiscal year 2011.

The President's budget for fiscal year 2011 (submitted in February 2010) contains the amounts that were appropriated in advance in P.L. 111-117 for the three VA health care accounts and requests additional amounts for medical and prosthetic research and for the spending of collections. Accordingly, the total amount available for VA medical care and research in 2011 will include the advance appropriations made in 2010 modified by funding provided in the appropriation act for 2011. See Sidath Viranga Panangala, *Veterans Medical Care: FY2011 Appropriations*, CRS Report for Congress R41343 (Congressional Research Service, July 27, 2010).

2. The projections shown in this report are from CBO's January 2010 report *The Budget and Economic Outlook: Fiscal Years 2010 to 2020*. CBO recently released *The Budget and Economic Outlook: An Update* (August 2010), which updates CBO's baseline budget and economic projections. Those economic projections, however, are not sufficiently different from the ones in the January volume to affect the projections for VA presented in this report.

contingency operations (OCO).³ Among the nation's recent named overseas contingency operations are Operation Enduring Freedom in Afghanistan and, in Iraq, Operation Iraqi Freedom and Operation New Dawn. (The latter began with the withdrawal of the final U.S. combat brigade from Iraq in August 2010.) VA specifically tracks military personnel who actually served in the theater of operations, in contrast to military personnel who supported those operations from locations elsewhere in the world, including the United States. CBO projects the costs of treating veterans who have or will have served in those theaters as well as personnel who may serve in theater in future such operations over the next 10 years. CBO projects those costs because the war-related medical needs of OCO veterans have garnered significant attention among policymakers and the public and because VA data show that the use of medical services by those veterans is significantly different from that of most other veterans.

Before proceeding with the analysis and a discussion of the methods used to make the projections, this report presents an overview of VA's health care program and the trends in the number of veterans who enroll and the number who seek health care at VA.

The Health Care Program of the Department of Veterans Affairs

With appropriations of \$48 billion in 2010 for medical care and research, the VHA operates VA's medical centers and clinics and provides health care and rehabilitation services to veterans. VHA's medical personnel also provide emergency management services, train medical students and other health care providers, and conduct research. The health care system consists of about 150 medical centers, 950 ambulatory care and community-based outpatient clinics, 230 Vet Centers (which provide readjustment counseling and outreach services), 130 nursing homes, and more than 150 rehabil-

itation and home care programs. The outpatient clinics tallied over 73 million visits for services in 2009, including routine health assessments, specialty care, and outpatient surgery. In total, VHA employed about 235,000 full-time-equivalent employees in 2009, including nearly 16,000 physicians and 66,000 nurses and nursing assistants.⁴

Trends in the Number of Veterans Enrolled and Being Treated by VA

Eligibility for VA's health care services is based primarily on a veteran's military service. In addition, VA operates an eight-tier priority system that establishes a veteran's eligibility and priority for using its health care services (see Box 1). Veterans with the highest priority include those who have service-connected disabilities, low income, or both; those with the lowest priority have higher income and no compensable service-connected disabilities.⁵

The number of veterans using VA's health care services grew substantially after enactment of the Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104-262, 110 Stat. 3177). That law required VA to provide care to certain types of veterans, such as those with service-connected disabilities, and permitted VA to offer services to additional veterans if funding permitted. It also required VA to manage the provision of its services through an enrollment system. In 1999 (the year VA's enrollment system became fully operational), VA permitted all veterans to enroll, even those with relatively high income. In the 1990s, VA also began restructuring its delivery of care, shifting from a hospital-based system to one focused more on ambulatory care (care that is delivered in an outpatient setting). New outpatient clinics have made medical care more accessible to veterans who do not live close to VA hospitals. Enrollment, which had stood at 4.9 million in 2000, reached 7.2 million in 2003, an average annual increase of 13 percent (see Figure 1).

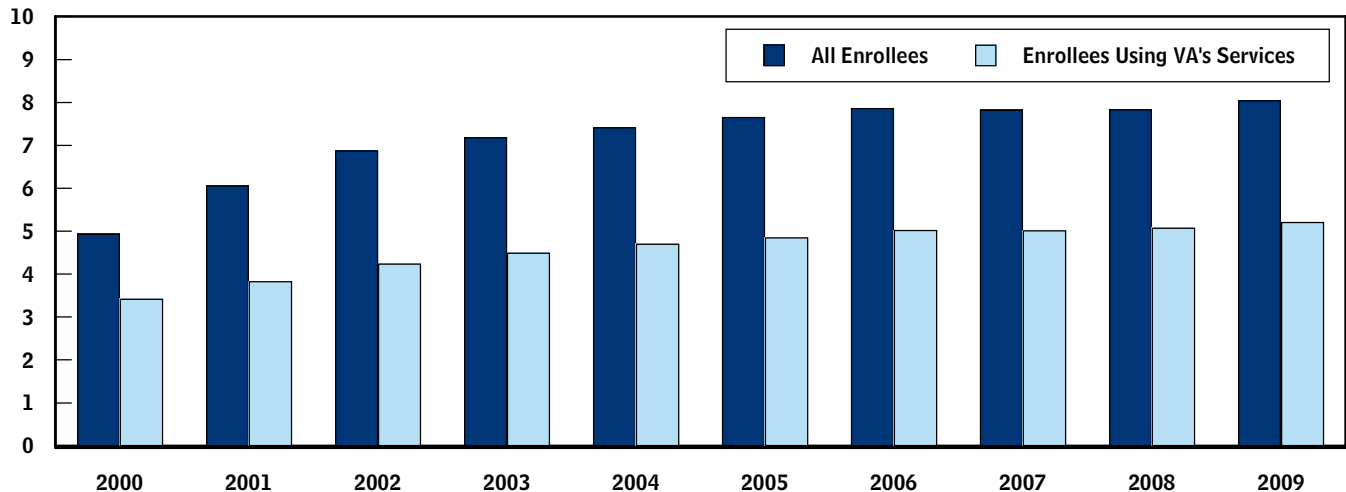
3. According to 10 United States Code (USC) 101[a][13], the term "contingency operation" refers to a military operation that "(A) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (B) results in the call or order to, or retention on, active duty of members of the uniformed services under section 688, 12301 (a), 12302, 12304, 12305, or 12406 of USC title 10, chapter 15 of USC title 10, or any other provision of law during a war or during a national emergency declared by the President or Congress."

4. The number of full-time-equivalent employees equals the number of employees on full-time schedules, plus the number of employees on part-time schedules converted to a full-time basis.

5. Veterans may seek compensation for service-connected disabilities from the Veterans Benefits Administration. VBA rates a disability as zero to 100 percent disabling in increments of 10 percent. Disability payments are determined by a veteran's disability rating; VBA may determine that some veterans have service-connected disabilities but that those conditions are not sufficiently disabling to qualify for VA compensation (that is, the disabilities are not compensable).

Figure 1.**Enrolled Veterans and the Number Who Use VA's Health Care Services**

(Millions)



Source: Congressional Budget Office based on data from the Department of Veterans Affairs (VA).

In any given year, not all enrolled veterans seek medical treatment from VA. The number of veterans treated by VA totaled 3.4 million in 2000 and grew to 4.5 million in 2003, increasing at an average annual rate of 9 percent—even though the number of veterans in the U.S. population has been falling by 1 percent to 2 percent each year since at least the mid-1990s. The growing number of patients reflected both the opening of enrollment and the restructuring of VA's system for providing health care. By 2003, VA did not have sufficient funding to meet the increased demand for its services (for example, there were long waiting lists to receive an appointment). That situation prompted the Secretary of Veterans Affairs in 2003 to grant priority access for health care services to veterans with service-connected disabilities. The Secretary also suspended new enrollment for higher-income veterans (those in the lowest priority group, P8) at that time, but veterans already enrolled in P8 were permitted to continue using VA's services. Since then, growth in annual enrollment and in the number of veterans treated by VA has slowed dramatically, to an average of 2.3 percent and 3.0 percent each year, respectively. In 2009, 8.0 million veterans were enrolled and 5.2 million were treated.⁶

The suspension of enrollment for veterans with higher income was eased somewhat in June 2009, when VA reopened P8 enrollment to veterans whose income exceeded the current income thresholds by 10 percent or less.⁷ VA anticipates that 200,000 of an estimated 900,000 veterans made eligible by the easing of that

income restriction will enroll by the end of 2010 and that smaller annual increases in enrollment will occur thereafter among the remaining veterans who are newly eligible on the basis of income.

Low-income veterans (P5s) accounted for the largest share of all enrollees—28 percent—in 2009 (see Figure 2 on page 6). Veterans whose income was above the VA means-test thresholds and who had no compensable service-connected disabilities (P7s and P8s) together made up 28 percent of enrollees; the vast majority of that group were P8s. Veterans with service-connected disabilities (those in P1 through P3) made up 35 percent of all

6. VA treated about 500,000 additional patients who were not veterans in 2009. Those patients included employees (who receive services such as tests and vaccinations required for employment at VA facilities); dependents and survivors of disabled veterans who are eligible for the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA); and patients seen through sharing agreements with other providers, including the Department of Defense's TRICARE program.
7. VA applies nationwide means-test thresholds and geographic income thresholds to determine priority for enrolling in VA health care. The geographic thresholds acknowledge variations in the cost of living in different parts of the country. For enrollment in P8, a veteran's income must not exceed the current VA means-test thresholds (\$29,402 for a veteran with no dependents in 2010) or the higher VA geographic income thresholds by more than 10 percent.

Box 1.**Eligibility, Priority Groups, and Cost Sharing for Veterans' Health Care**

Eligibility for health care services provided by the Department of Veterans Affairs (VA) is based primarily on veterans' military service. Generally, veterans who have served in the active components must have served 24 continuous months on active duty and been discharged under other than dishonorable conditions.¹ Reservists and National Guard members who were called to active duty under a federal order also qualify for health care benefits if they completed the term for which they were called and were granted an other than dishonorable discharge.²

Those broad criteria, however, do not necessarily translate into access to medical treatment. Because VA's medical system relies on funding provided by annual appropriation acts, access to care depends on the amount of funding that the Congress makes available.

VA may, and does, restrict enrollment according to the resources available. Historically, VA has focused its resources on providing medical services to veterans who have service-connected conditions—that is, medical conditions that occurred or worsened during military service. Beginning in the 1970s, medical care was also offered to low-income veterans who had no service-connected conditions. The Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104-262, 110 Stat. 3177) mandated that VA deliver

health care services to veterans with service-connected disabilities, to those unable to pay for necessary medical care, and to specified groups of veterans, such as former prisoners of war and veterans of World War I. The legislation also permitted VA to offer services to all other veterans to the extent that resources and facilities were available.

To aid the management and delivery of health care services, the Congress required VA to develop and operate a system for enrolling veterans for those services. VA currently assigns veterans to one of eight categories that indicate their priority for enrollment. The eight priority groups reflect such factors as the presence and extent of a disability that is related to military service and a veteran's income. Disabled and low-income veterans are given a higher priority, and veterans who have higher income and do not have a compensable service-connected disability (that is, a medical condition that is disabling to the extent that VA provides compensation) receive a lower priority. The Secretary of Veterans Affairs decides each year whether VA's budget for medical care is sufficient to serve veterans in all priority groups who seek care. If not, veterans deemed to have a lower priority may face restrictions on new enrollment or lose their eligibility.

The priority groups, from highest to lowest (P1 through P8), are as follows:

1. Enlisted service members who entered service before September 1980 and officers who first did so before October 1981 need not meet the time-in-service requirements.
2. Other veterans and reservists not meeting those conditions may still be eligible. For example, some service members who were discharged or released from active duty for a disability that occurred or worsened during service or who received an "early out" may be eligible.

- **P1**—Veterans who have service-connected disabilities (SCDs) rated 50 percent or more disabling (or two or more SCDs that together are 50 percent or more disabling); veterans deemed to be unemployable because of service-connected conditions.

Continued

Box 1.**Continued****Eligibility, Priority Groups, and Cost Sharing for Veterans' Health Care**

- **P2**—Veterans with SCDs rated 30 percent or 40 percent disabling.
- **P3**—Veterans who are former prisoners of war; were awarded the Purple Heart; were discharged because of SCDs; have SCDs rated 10 percent or 20 percent disabling; or were disabled as a result of treatment or vocational rehabilitation.
- **P4**—Veterans who are receiving aid and attendance benefits or are housebound and veterans whom VA has determined to be catastrophically disabled as a result of a non-service-connected illness or injury.
- **P5**—Veterans who do not have SCDs or who have noncompensable SCDs rated zero percent disabling and whose annual income and net worth are below VA's national means-test thresholds; veterans who are receiving VA pension benefits; and veterans who are eligible for Medicaid benefits.³
- **P6**—Veterans seeking care solely for disorders associated with exposure to chemical, nuclear, or biological agents in the line of duty (including, for example, Agent Orange); veterans who have compensable SCDs rated zero percent disabling; and recently discharged combat veterans who are within a five-year period of enhanced eligibility and benefits. (Most veterans of the ongoing overseas contingency operations are initially assigned to P6.)
- **P7**—Veterans who have no SCDs (or who have noncompensable SCDs rated zero percent disabling), whose annual income or net worth is above the VA means-test thresholds and below the VA national geographic income thresholds, and who agree to make copayments.⁴
- **P8**—Veterans who have no SCDs (or who have noncompensable SCDs rated zero percent disabling), whose annual income or net worth is above the VA means-test thresholds and the VA national geographic income thresholds, and who agree to make copayments.

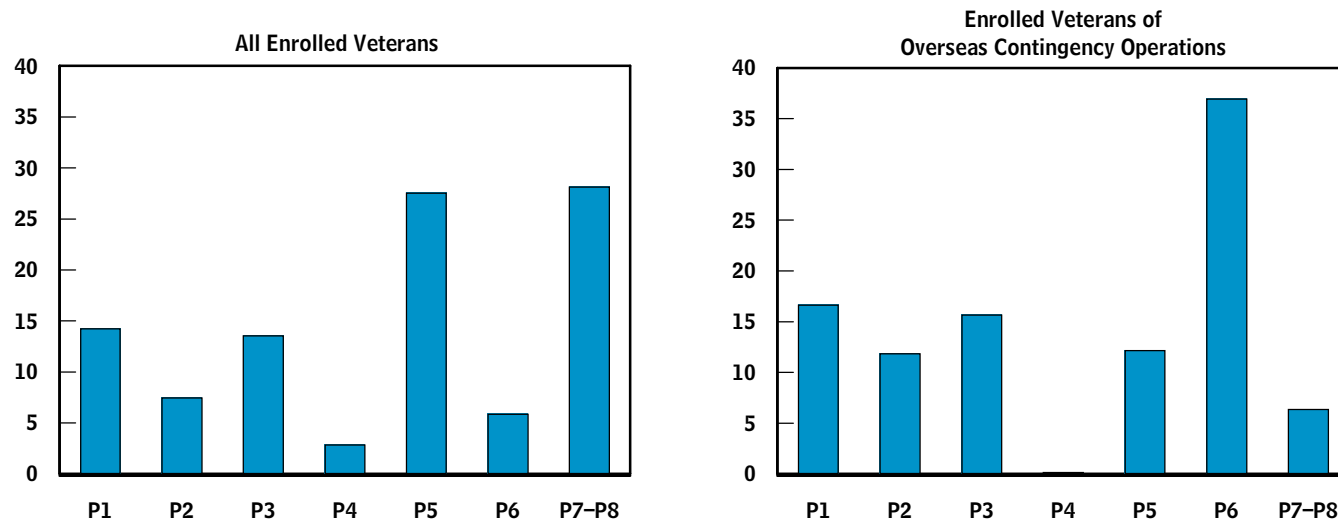
Through the Veterans Health Administration, VA provides ambulatory visits, inpatient services, and prescription medications at no charge to many veterans, including those who have service-connected disabilities rated 50 percent or greater and those seeking treatment for a service-connected condition. Copayments (\$15 for primary care visits, \$50 for specialty care visits, and \$9 for a 30-day supply of medication in 2010) apply to veterans in P7 and P8 for care that is not related to a service-connected condition and may also apply to veterans in P2 through P6. Additional copayments for inpatient and other services may also apply.

3. An SCD is compensable if monetary compensation is authorized for payment. A disability rated zero may be compensable if it entitles the veteran to special monthly compensation; a combination of two or more such ratings may be compensable if they interfere with the veteran's ability to work.

4. Unlike the VA means-test thresholds, which apply nationwide, the geographic income thresholds acknowledge variations in the cost of living in different parts of the country.

Figure 2.**Distribution of Enrolled Veterans, by Priority Group, 2009**

(Percent)



Source: Congressional Budget Office based on data from the Department of Veterans Affairs (VA).

Note: VA's enrollment system assigns veterans to one of eight priority groups (P1 through P8). Veterans with service-connected disabilities that are rated 50 percent or more disabling are in P1 (highest priority); those with higher income and no compensable service-connected disabilities are in P8 (lowest priority). For definitions of the priority groups, see Box 1 on page 4.

a. Overseas contingency operations include current military operations in Iraq and Afghanistan and related activities.

enrollees, and two-fifths of them (14 percent of all enrollees) had a rating of 50 percent or higher (P1).

Eligibility and Enrollment of Veterans of Overseas Contingency Operations

The U.S. military is currently engaged in overseas contingency operations in Iraq and Afghanistan and a number of other locations. Qualified service members who have served on active duty in combat operations since November 1998, including reservists and members of the National Guard, are eligible to use VA's health care system after separating from active military service.⁸ The Veterans Programs Enhancement Act of 1998 (P.L. 105-368) gave combat veterans a two-year period of eligibility for enrollment after leaving active duty, waiving any requirements for them to document that their income is below established thresholds or to demonstrate a service-connected disability, which veterans who have not served in combat operations must do. In 2008, the Congress extended the eligibility period to five years.⁹

8. VA disqualifies certain veterans from receiving health care benefits—for example, those who receive a dishonorable discharge.

Under those authorities, VA provides free health care for medical conditions potentially related to military service in combat operations. VA also treats combat veterans for non-combat-related conditions but may bill the veteran's third-party insurance or charge the veteran a copayment unless he or she is in a high priority group. About 1.1 million veterans of the current military operations had become eligible for VA's health care services through September 2009—575,000 members who had served in the active component and 520,000 members who had served in the National Guard and reserves.¹⁰

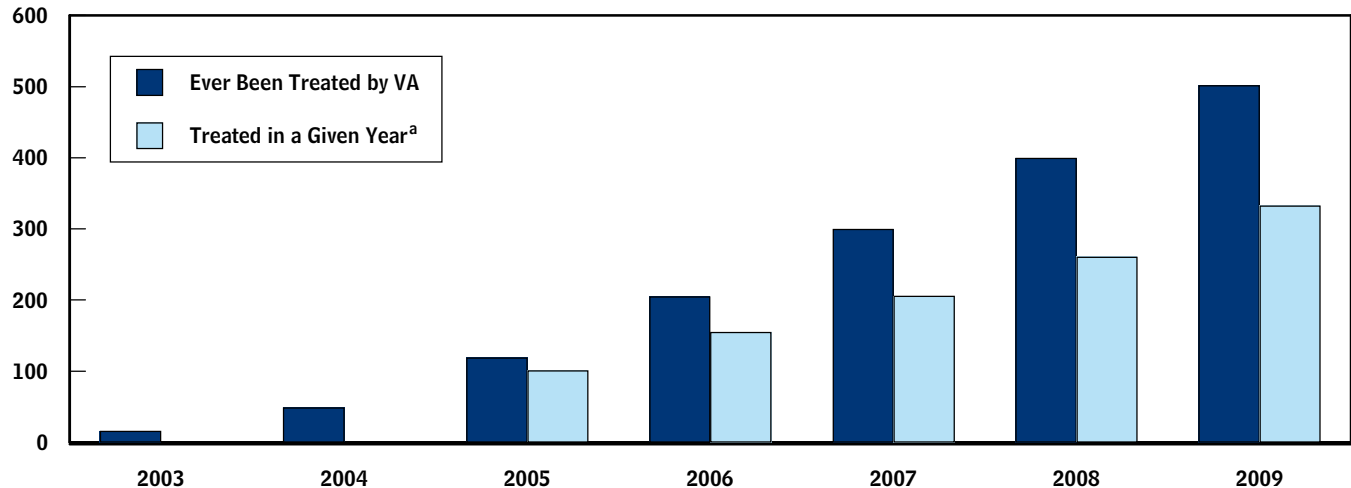
Most veterans of overseas contingency operations are placed in P6 upon enrollment, although some of them may be moved into higher priority groups (for example, if at any point they are deemed disabled as a result of their

9. See title XVII of the National Defense Authorization Act for Fiscal Year 2008, P.L. 110-181, 122 Stat. 493.

10. Some members of the National Guard and reserves who have returned from current military operations may retain their reserve affiliations—making them potentially subject to future call-ups—while at the same time being immediately eligible to enroll for VA health care.

Figure 3.**Number of Veterans of Overseas Contingency Operations Treated by VA**

(Thousands)



Source: Congressional Budget Office based on data from the Department of Veterans Affairs (VA).

Note: Overseas contingency operations include current military operations in Iraq and Afghanistan and related activities.

a. Data on veterans of overseas contingency operations who have been treated by VA in a given year are not available before 2005.

military service). Enrolled OCO veterans may continue to use VA's services when the five-year period of enhanced eligibility ends, but their priority group may change, depending on their disability status and income. In particular, OCO veterans may be moved to a lower priority group, including P8—an exception to the general freeze on new enrollments in that group. Once reclassified, veterans are required to make the standard copayments for their priority group.

Although most OCO veterans are initially placed in P6, just 37 percent of the 560,000 OCO enrollees in 2009 were in that priority group (see Figure 2). Forty-four percent had service-connected disabilities (P1 through P3), and a little over one-third of them (17 percent of all OCO enrollees) had a disability rating of 50 percent or higher (P1). Less than 1 percent were catastrophically disabled with non-service-connected disabilities (P4). Another 12 percent had income or net worth below the VA thresholds (P5), and the remaining veterans (6 percent) had income or net worth that exceeded the means-test thresholds and were enrolled in P7 or P8.¹¹

Nearly one-half of OCO veterans had used VA's health care services through September 2009. The number of OCO veterans who have ever used that system has grown rapidly, by roughly 100,000 veterans per year in the past

several years (see Figure 3).¹² Of the 575,000 active-component members who separated from military service, more than 270,000 (47 percent) had used those services at least once (see Box 2). An additional 520,000 members of the reserves or National Guard were demobilized and returned to civilian life, and 235,000 of them (45 percent) had used VA's services at least once. In total, almost 510,000 OCO veterans had sought care from VA since the overseas contingency operations began in 2002.¹³

11. The distribution of OCO veterans among priority groups will probably change between now and 2020. As large numbers of combat veterans enter VA's health care system over the next few years, the number of P6 veterans will increase. In later years, however, that number will decrease as the special eligibility period for combat veterans expires and veterans are reclassified.
12. Despite the growth in use of services, not all eligible veterans with service-connected disabilities are enrolled in VA's health care system. According to VA, almost 40 percent (nearly 85,000) of OCO veterans who receive disability compensation had not used VA's health care services as of September 2008.
13. The source for these statistics and those in the following paragraph is Department of Veterans Affairs, Veterans Health Administration, Office of Public Health and Environmental Hazards, *Analysis of VA Health Care Utilization Among U.S. Southwest Asia War Veterans* (October 2009).

Box 2.**Medical Status of Service Members and Veterans Who Served in Iraq and Afghanistan and Their Use of Health Care Services**

The United States has been involved in overseas contingency operations (OCO) in Afghanistan and Iraq since October 2001 and March 2003, respectively. Some of the troops who have served in those operations have been injured or have developed medical conditions requiring treatment. This box discusses the extent of service members' medical problems in theater, including post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI) among deployed troops.

Medical Conditions While Deployed

Widespread use of body armor and recent advances in battlefield medicine have enabled many soldiers to survive what might otherwise have been fatal injuries. According to data from the Department of Defense (DoD), through December 2009, 57,600 service members had been evacuated from the Iraq and Afghanistan theaters for medical reasons: 10,900 (19 percent) were wounded in battle (an additional 25,500, not included in this total, were wounded but could return to duty without the need for medical evacuation); 12,100 (21 percent) had a non-battle-related injury; and 34,600 (60 percent) had a disease or other medical condition. Among the latter group, the most common reasons for being airlifted were disorders of the musculoskeletal system or connective tissue (19 percent) and mental disorders (15 percent). The vast majority of service members evacuated for battle-related injuries through 2007 were able to resume their military duties: According to DoD, only one-quarter of them had separated from military service for any reason by the end of that year.

Some service members have had severely disabling injuries, such as amputations and serious brain injuries, while deployed to Iraq or Afghanistan.¹ Although firm data on the number of seriously ill or disabled veterans of those U.S. military operations are not readily available, a recent study sheds some light

on the magnitude. The authors estimate that each year during the 2003–2008 period, about 720 seriously wounded, injured, or ill service members, on average, needed a caregiver and that those caregivers were required for an average of 19 months.²

Data from the Department of Veterans Affairs' (VA's) Traumatic Injury Protection Under Servicemembers' Group Life Insurance (TSGLI) program also provide a rough estimate of the number of service members who have been severely disabled by war-related injuries. TSGLI provides a financial benefit to service members who experience certain traumatic injuries (on or off duty), such as hearing loss, amputation, or severe brain injury. (The benefit does not cover all injuries that may lead to severe impairment.) Through September 2009, a total of 4,800 veterans of contingency operations, equal to 1 percent of all veterans who served there and are enrolled in VA's health care system, had received benefits from the TSGLI program.

Troops also seek medical care for less severe conditions while deployed. Service members in the Central Command (CENTCOM), which oversees U.S. military missions in the Middle East, had 2.4 million medical encounters from January 2005 through December 2009. (A medical encounter is any contact a service member has with DoD's medical system for treatment.) Of those encounters, 22 percent were for injuries (battle- and non-battle-related) and 9 percent were for psychiatric illnesses. Despite the number of medical encounters tallied, 85 percent of returning troops who completed a DoD health assessment within three to six months of their return from deployment self-reported their health status as excellent, very good, or good,

1. Matthew S. Goldberg, "Death and Injury Rates of U.S. Military Personnel in Iraq," *Military Medicine*, vol. 175, no. 4 (April 2010), pp. 220–226.

2. Eric Christensen and others, *Economic Impact on Caregivers of the Seriously Wounded, Ill, and Injured* (Alexandria, Va.: CNA Corporation, April 2009), p. 3. By comparison, VA provides long-term care (institutional and noninstitutional care) to more than 100,000 veterans, or 1.5 percent of VA enrollees.

Box 2.**Continued**

Medical Status of Service Members and Veterans Who Served in Iraq and Afghanistan and Their Use of Health Care Services

although 40 percent had physical concerns and 40 percent stated they had mental health concerns.

PTSD and TBI

Two medical conditions that troops develop in theater have received widespread attention. PTSD is an anxiety disorder induced by exposure to a traumatic event and is characterized by symptoms that include reexperiencing the traumatic event, hyperarousal (such as irritability or exaggerated startle response), and diminished responsiveness to or avoidance of stimuli associated with the trauma. TBI is an injury to the head arising from sudden trauma to the brain, resulting in a decreased level of consciousness, amnesia, or neurological or intracranial abnormalities. TBI is classified at the time of the injury as mild, moderate, or severe. Almost 90 percent of the service members diagnosed with that type of injury have a mild case, and the vast majority are expected to recover within one year after the injury.

A number of studies have estimated the prevalence of PTSD among military personnel and veterans who have served in Iraq or Afghanistan, but less is known about the prevalence of TBI among that population. (Prevalence is an estimate of cases in a population whether or not the individual has received a diagnosis from a medical professional.) Estimates of the prevalence of PTSD or symptoms of PTSD among those personnel generally range between 5 percent and 25 percent, depending on the study's methodology and the population it sampled.³ Fewer studies have estimated the prevalence of TBI in theater, partly because programs at DoD and VA to screen service members are relatively new and because TBI and related symptoms are particularly difficult to diagnose months after the initial injury.⁴

Recent studies indicate that between 19 percent and 23 percent of service members and veterans who have deployed to Iraq or Afghanistan may have had TBI, depending on the study's methodology and the population it sampled.⁵ A limited body of research also suggests that a minority of service members who had TBI experience symptoms over the longer term that may have been caused by that condition. In one study, less than 20 percent of the group with suspected TBI had at least two symptoms upon their return home that might be attributable to that type of injury.⁶

No extant studies of the prevalence of either PTSD or TBI are definitive, however. Most studies surveyed subgroups of deployed personnel, such as Army infantry, and extrapolating the results to the general deployed population is problematic. Also, the survey instruments used to screen for a possible case of PTSD or TBI either have not been validated or do not produce highly accurate estimates of those conditions.⁷

3. For a survey of the literature, see Rajeev Ramchand and others, "Prevalence of PTSD, Depression and TBI Among Returning Service Members," in Terri Tanielian and Lisa H. Jaycox, eds., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Santa Monica, Calif.: RAND Corporation, April 2008), pp. 33–85.

4. DoD and VA have active outreach and awareness campaigns to encourage service members and veterans to seek treatment for PTSD. The departments also routinely screen all service members who have served in Iraq or Afghanistan (DoD) and veterans of those operations (VA) for PTSD and TBI and provide treatment for the conditions.

5. Terry Schell and Grant Marshall, "Survey of Individuals Previously Deployed for OEF/OIF," in Tanielian and Jaycox, eds., *Invisible Wounds of War*, pp. 87–115; and Heidi Terrio and others, "Traumatic Brain Injury Screening: Preliminary Findings in a US Army Brigade Combat Team," *Journal of Head Trauma Rehabilitation*, vol. 24, no. 1 (January/February 2009), pp. 14–23.

6. Terrio and others, "Traumatic Brain Injury Screening."

7. Rajeev Ramchand and others, "Prevalence of PTSD, Depression and TBI Among Returning Service Members"; and Heidi Golding and others, "Understanding Recent Estimates of PTSD and TBI from Operations Iraqi Freedom and Enduring Freedom," *Journal of Rehabilitation Research and Development*, vol. 46, no. 5 (October 2009), pp. vii–xiii.

Through September 2009, mental health problems and musculoskeletal disorders (disorders of the muscles, nerves, tendons, ligaments, joints, cartilage, or spinal disks) were the most common diagnoses among the OCO veterans who had used VA's health care services. According to VA, since 2002, about 245,000 veterans had cumulatively received at least a preliminary diagnosis for a mental health condition, and nearly 130,000 of them had visits that were coded in the VA system for post-traumatic stress disorder (PTSD). In addition, 265,000 veterans had visits that were coded for a musculoskeletal condition.¹⁴ Despite the large numbers of OCO veterans' visits, the resources devoted to OCO enrollees are much smaller than for other groups of veterans, primarily because OCO veterans are much younger and healthier. CBO expects the cost of treating OCO veterans to rise as they age.

Potential Costs of Providing Health Care to All Enrolled Veterans

VA's appropriations for medical care totaled \$48 billion for 2010—a little more than \$47 billion for health care services and about \$0.6 billion for medical research—a nominal increase of 8 percent over the appropriation for 2009.¹⁵ More than four-fifths of the 2010 obligations for medical care—\$42.4 billion—is allocated to providing services such as ambulatory care, inpatient acute care, pharmacy services, and dental care.¹⁶ The remainder funds long-term care for veterans (\$6.0 billion) and other health care initiatives and programs such as the Civilian

Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)—which provides benefits to certain dependents and survivors of disabled veterans (\$1.1 billion)—and readjustment counseling at Vet Centers (\$170 million).

In real (inflation-adjusted) terms, budget authority for VA's health care services and medical research increased at an average annual rate of almost 6 percent between 2004 and 2008, by 12 percent in 2009, and by 7 percent in 2010.¹⁷ With enrollment growing about 1 percent each year through 2008 and 3 percent in 2009, most of the additional funding was used to support greater use of services per enrollee and to cover the increases in costs for a medical visit or service. Annual resources averaged about \$5,600 (in 2010 dollars) per enrollee for 2009—an inflation-adjusted increase of 9 percent from the previous year's total of \$5,100. Greater use of services and higher costs of providing them each accounted for roughly half of that increase.¹⁸ By contrast, health expenditures per capita in the general U.S. population, as measured by the Centers for Medicare and Medicaid Services (CMS), were expected to grow by about 4 percent in 2009.

CBO estimated the resources that VA would require to treat all enrollees under two scenarios for the 2011–2020 period. Under different assumptions regarding the growth in enrollment and medical expenditures per enrollee, the resources required would increase from \$48 billion in 2010 to between \$69 billion and \$85 billion in 2020 (in 2010 dollars).

Analytic Method

To reflect the considerable uncertainty about future military operations, enrollment in VA health care, and the growth of medical expenditures in the economy, CBO formulated two scenarios. Each scenario involves two separate projections for the 2011–2020 period: one for veterans of overseas contingency operations and

14. Not all of those veterans ultimately received diagnoses of those conditions. Some of the visits produced “rule-outs”: The physician conducted an examination to determine whether the veteran had a particular medical condition and determined that he or she did not. Up to one-third of the mental health diagnoses were provisional pending further evaluation. The available data did not enable CBO to deduct rule-outs or provisional diagnoses from confirmed diagnoses.

15. The total of \$48 billion includes the authority to spend an anticipated \$3.0 billion from the Medical Care Collections Fund (MCCF). Title VIII of the Veterans Reconciliation Act of 1997 (P.L. 105-33) established the MCCF account and required that amounts collected or recovered from first- or third-party payers be deposited into that account and used for medical services for veterans.

16. An obligation is a commitment that creates a legal liability on the part of the government to pay for goods and services ordered or received. Such payments may be made immediately or in the future. Obligations during any year may exceed appropriations provided during that year because an agency may obligate funds that were provided in an earlier year.

17. Budget authority is the authority provided by federal law to enter into financial obligations that will result in immediate or future outlays involving federal government funds.

18. The higher costs of providing services may reflect some changes in the intensity and mix of services at VA. For example, patients may require longer office visits, or physicians may order the use of newer diagnostic methods instead of older ones—changes that are reflected not in the number of services used but in the cost per service provided. Likewise, if patients shifted from primary care visits to outpatient mental health visits for the same medical condition, the number of services would not change but the average cost of ambulatory services would change.

another for all other veterans. (CBO used a separate method for the OCO veterans because of their rapidly growing enrollment and because the types of services they use and the frequency with which they use them are different from those of most other veterans.) The two sets of projections were combined to derive total annual potential costs for VA's medical system.

Those costs can be projected several ways. One approach is to use a "top-down" model, in which the basic bundle of services a typical enrollee is expected to use remains the same over time, and a factor reflecting the year-to-year percentage growth in the cost of services is applied across the board. That method, however, does not allow the mix of enrollees, or their use of services, to change over the projection period. An alternative approach is to build a "bottom-up" model based on specific medical conditions, but that method requires analyzing data for a multitude of conditions, developing probability estimates that those conditions would occur, and estimating the yearly costs of treating a patient who has that medical ailment. The large number of medical conditions and the lack of pertinent data on costs make that approach infeasible to undertake alone.

CBO used a mix of those two methods to project the use of health care services and VA's potential costs over the 2011–2020 period. For the non-OCO enrollees, CBO built up the cost projection for each of the eight priority groups from separate estimates of their use of services (measured as full-time-equivalent users) and the annual cost per user in each group. The number of users was computed as the number of non-OCO enrollees times the reliance of veterans within a priority group on VA; reliance is the portion of veterans' costs incurred by VA as a percentage of their total annual health care costs provided by any source.¹⁹ The annual cost per user was estimated from historical data pertaining to veterans in each priority group. The costs per user were then inflated using a common rate for all priority groups (but different inflation rates for the two scenarios, as discussed below). For the OCO veterans, CBO projected the potential costs on the basis of broad categories of services, incorporating observed changes in the OCO veterans' use of services in the years following enrollment. (See Appendix A for greater detail on the procedures CBO used.)

19. VA calculates reliance as its expenditures on veterans' health care divided by its estimate of the total expenditures on health care devoted to those veterans, including costs paid by the public sector, by private insurance, or out of pocket by the veteran.

The blended approach has several advantages over a strictly bottom-up or top-down approach. The amount of information required is less extensive than that required by a fully bottom-up method. Compared with a top-down approach, the blended approach is more flexible and can more easily and accurately project changes in the mix of enrollees or in the services they use than can a more aggregate method. That feature is especially important for projections under Scenario 2, which incorporates an assumption that the growth in P8 enrollment and in the use of certain services among VA enrollees outpaces that in the general population.

For Scenario 1, CBO assumes slower growth in enrollment and in medical expenditures per enrollee than it does in Scenario 2 (see Table 1). Specifically, for Scenario 1, CBO assumes that VA's enrollment policies in 2010 remain in effect (that is, veterans whose income is no more than 10 percent above the thresholds may enroll) and that the number of troops deployed to overseas contingency operations drops to 30,000 service members by 2013 and stays at that number through 2020. Within each priority group, enrollees' use of medical services and the associated costs are assumed to grow at about the same rates as those projected for the general U.S. population. That path would represent a slowdown in the relative rate of spending growth in the VA system because average expenditures per capita grew faster among VA enrollees than in the general population from 2003 through 2007.²⁰

For Scenario 2, CBO assumes that VA further relaxes its restrictions on enrollment for veterans who have higher income (those in P8) and that deployments to overseas contingency operations drop more slowly than in Scenario 1, reaching 60,000 by 2015 and staying at that number through 2020. CBO also assumes that growth in VA's health care expenditures for each priority group is about 30 percent above the rates anticipated for the general population, which is twice as fast as the rate VA experienced between 2003 and 2007.

20. Over the longer period of 2000 through 2007, average expenditures per capita grew at a slower pace for VA enrollees than for the general population. However, the growth in waiting lists for appointments through 2003 and the restrictions on enrollment imposed in that year suggest that expenditures did not keep pace with the increase in veterans' demand for services. The 2003–2007 period reflects the effects of VA's policies to provide sufficient services to all enrolled veterans.

Table 1.
Assumptions Underlying the Scenarios

	Scenario 1	Scenario 2
Eligibility to Enroll for VA Health Care		
Veterans of overseas contingency operations	Deployed troop strength for those operations drops to 30,000 by 2013	Deployed troop strength for those operations drops more slowly, to 60,000 by 2015.
All other veterans	VA policies in place at the beginning of 2010 remain in effect	Enrollment allowed for veterans whose income exceeds thresholds by 30 percent or less; all other VA policies in place at the beginning of 2010 remain in effect
Per Capita Growth in Medical Expenditures	About the same rate as for the general population ^a	30 percent faster than in Scenario 1

Source: Congressional Budget Office.

Notes: Overseas contingency operations include current military operations in Iraq and Afghanistan and related activities.

VA = Department of Veterans Affairs.

- a. Projections of growth in medical expenditures for the general population are based on data from the Centers for Medicare and Medicaid Services and others.

Both scenarios rely on information about projected enrollment that is consistent with VA's 2010 and 2011 budget requests, which were submitted to the Congress before the enactment in March 2010 of the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Certain provisions of that legislation will, in the latter part of the coming decade, lower the costs of obtaining health insurance for some veterans. Some of those veterans will seek less care from VA than they would have without the recent legislative changes, reducing the potential costs for the VA health care system. Conversely, beginning in 2014, that legislation will require most residents of the United States to have a certain level of health insurance, or "minimum essential coverage" as defined in the law, and (with some exemptions) it will impose financial penalties on people who do not meet that requirement. More recent legislation states that the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services, will determine whether the health care provided by VA qualifies as minimum essential coverage.²¹ If the Secretary of Veterans Affairs determined that VA health care does qualify, some eligible veterans who are currently neither enrolled in VA nor otherwise insured would choose to enroll in VA to avoid any penalties for being uninsured.

21. See P.L. 111-173, an act to clarify the health care provided by the Secretary of Veterans Affairs that constitutes minimum essential coverage.

That factor alone would increase potential costs for the VA health care system.

On balance, CBO's preliminary analysis indicates that the effects of all three laws on the projected number of enrollees and the resources they would require would probably be either a slight increase or a slight decrease, but in neither case would those effects materially change the projections in this report. In particular, OCO veterans would continue to account for a small share of VA's costs with the new laws in place. Similarly, the relative importance of the factors responsible for the differences between Scenarios 1 and 2 would remain essentially the same if the recent changes in law were reflected in the analysis.

More generally, CBO's projections should not be viewed as precise predictions of the future costs of providing health care to all veterans enrolled in the VA health care system. Actual budgetary outcomes are almost certain to differ from CBO's projections because of future legislative actions and because of unanticipated changes in economic conditions, health insurance markets, prices for medical products and services, medical technology, and other factors.

Projected Enrollment, Use of Services, and Growth in Medical Expenditures per Enrollee

The most important factors determining the potential costs of VA's health care system over the 2011–2020

period are enrollment, veterans' use of VA's services, and the growth in expenditures per enrollee.

Enrollment. Altogether, 8 million of an estimated 23 million veterans were enrolled in VA's health care system in 2009. The number of enrollees over the projection period will depend on VA's policies about enrollment, cost sharing, and other factors; the size of the veteran population; and the relative attractiveness of VA's health care services.

Using data from VA and the Department of Defense, CBO projects that total enrollment would grow to 8.8 million in 2016 under Scenario 1, or by 10 percent, even though the number of veterans in the population is expected to fall to about 21 million by 2016. The projected boost in enrollment is entirely attributable to two factors: the increased enrollment of OCO veterans and the addition of veterans who are newly eligible because their income exceeds VA's thresholds by no more than 10 percent. The former group accounts for 7 percentage points of the increase and the latter for the remaining 3 percentage points. The largest increases in annual enrollment would occur earlier, as the bulk of newly eligible P8s and OCO veterans enroll.²² Other than those two groups of veterans, new enrollments would be roughly offset by veterans who die during the projection period. For all veterans, overall enrollment is projected to decline slightly after 2016, falling to 8.7 million by 2020.

Under Scenario 1, CBO assumes that the number of service members deployed to Iraq, Afghanistan, and related activities will decline sharply, from an average of approximately 220,000 active-duty, reserve, and National Guard personnel during 2009 to only 30,000 by 2013 and will remain at that number thereafter. Enrollment of those personnel would grow from about 560,000 in 2009 to 1.4 million in 2020, or 16 percent of all enrollees.

Between the easing of the income restriction in 2009 and the end of the projection period in 2020, about 300,000 newly eligible P8s (whose income is as much as 10 percent above VA's income thresholds) would enroll for health care services, CBO projects. According to VA, about 900,000 veterans are in that income bracket and would be eligible to enroll. Not all of them would choose to do so, however, and the number who would enroll is

difficult to predict. CBO estimates that of all veterans who were eligible to enroll—and would be classified as P8 if they did enroll—less than 20 percent were actually enrolled at the end of 2008. That figure, however, does not provide a direct estimate of their propensity to enroll, because enrollment of new P8s had been barred since 2003.²³ To estimate the number of additional P8 enrollees over the projection period, CBO assumes that the percentage of newly eligible P8s who would enroll would gradually approach the roughly 40 percent share of P7 veterans (the group most similar to P8 veterans) who are enrolled.

Assuming a larger deployed force than in Scenario 1, CBO projects that total enrollment in Scenario 2 would reach 9.2 million in 2016 and gradually increase to 9.3 million in 2020. The projection incorporates the assumption that deployment peaks at an average of 235,000 troops for 2010, drops more slowly than under Scenario 1 through 2014, levels out at 60,000 at the beginning of 2015, and remains at that number thereafter. The total number of OCO personnel who would enroll would grow to 1.7 million in 2020, or 18 percent of all enrollees.

Under Scenario 2, CBO assumes that VA will open enrollment to veterans whose income is as much as 30 percent above VA's income thresholds in 2011, making an additional 1.5 million veterans eligible to enroll compared with Scenario 1. Using the same method to calculate additional P8 enrollees as in Scenario 1, CBO estimates that enrollment in 2020 would be higher in Scenario 2 by 340,000 veterans, a difference of 4 percent. Those additional veterans are also assumed to receive the same amount of care that currently enrolled P8 veterans are expected to receive in future years.²⁴

The majority of enrolled veterans either had not deployed to overseas contingency operations and were assigned to P1 through P7 or had enrolled in P8 before June 2009,

22. Annual growth in the number of full-time-equivalent enrollees is about one-third lower than the growth in overall enrollment because the new enrollees are expected to rely less on VA for their health care.

23. Combat veterans are an exception to that policy. They are permitted to remain enrolled in P8 after their five-year period of special eligibility ends, although they may be reclassified into a different priority group on the basis of standard criteria.

24. Although CBO does not analyze this policy option, removing all income-based restrictions on enrollment could result in a newly eligible pool of nearly 10 million additional veterans. Assuming that the pattern of enrollment for those veterans was similar to that for P7s, about 4 million additional veterans would probably choose to enroll over the 20 years or more following the policy change.

when the income restrictions were eased. The number of such veterans would be the same under both scenarios and is projected to remain stable through 2016 and then decline by roughly 5 percent by 2020.²⁵ Enrollment will remain stable for the first part of the decade because CBO expects VA to enroll an ever larger share of non-OCO veterans who are not newly eligible on the basis of income, continuing a trend that began several years ago. For the past few years, the share of those veterans who have enrolled has increased annually by an average of about 1 percentage point, probably in part because VA has added new outpatient clinics and adopted new technologies to make VA care more accessible to veterans. On the basis of historical trends and other factors, CBO projects that the percentage who enroll will continue to increase, reaching 37 percent of non-OCO veterans by 2015, up from 32 percent in 2008, even without the easing of the restriction on income for P8s.²⁶

Use of VA's Health Care Services. On average, enrollees depended on VA for about 23 percent of their health care (as measured in dollars) in 2008, VA estimates, although the extent to which they relied on VA varied by priority group. Veterans with higher income (P7 and P8 enrollees) had, on average, the lowest rates of reliance on VA, partly because they have the highest rates of medical coverage outside VA (see Figure 4 and Box 3). Veterans in those groups—who also account for the largest portion of enrollees over the age of 65 and are therefore eligible for Medicare—relied on VA for just over 10 percent of their medical care. By contrast, the most disabled veterans (those in P1 and P4) and the poorest veterans (P5) received about 35 percent and 28 percent of their health care from VA, respectively. That greater reliance is reflected in their use of services; they are the heaviest

users of some categories of care, such as inpatient hospital care and ambulatory care (see Appendix B for further detail on the use of categories of services). Many of those enrollees have no out-of-pocket costs for their care at VA—a benefit that probably contributes to their higher use of VA's services.

Reliance and the amount of care obtained from VA depend on many factors: veterans' characteristics—such as age, sex, and morbidity (the incidence of ill health); the availability of other health care options; and the characteristics of the VA medical system (including the convenience of VA's facilities, the ease of scheduling an appointment, and the enrollees' perceptions of the quality of the care they receive). Reliance rates among priority groups have remained relatively stable through the past several years. CBO assumes that they will remain so through the projection period under both scenarios; in a later section, CBO presents a sensitivity analysis in which reliance varies.

Expenditures per Enrollee. In 2008, VA's average expenditure for medical care was about \$5,000 (in 2010 dollars and measured as outlays per enrolled veteran). That care includes all health care services, medical research, nursing home care, and special programs and initiatives. Health care services, which accounted for the largest share of spending, averaged about \$4,300 per enrolled veteran but varied substantially by priority group. Average expenditures ranged from about \$1,500 per P6 enrollee (veterans of recent combat and certain other veterans) to \$15,000 per P4 enrollee (veterans who have catastrophic disabilities that are not service connected or who receive certain VA benefits) (see the left-hand panel of Figure 5 on page 18). The most severely disabled veterans (those in P1) were the second-most-expensive group; spending on their health care services averaged about \$9,500. For all other priority groups, average expenditures ranged between 15 percent and 55 percent of those for P1 veterans.

VA calculates an index of the resources that would be expended to treat the average enrollee in each priority group if, hypothetically, reliance was the same for all of them. The index reflects differences between priority groups in such characteristics as morbidity.

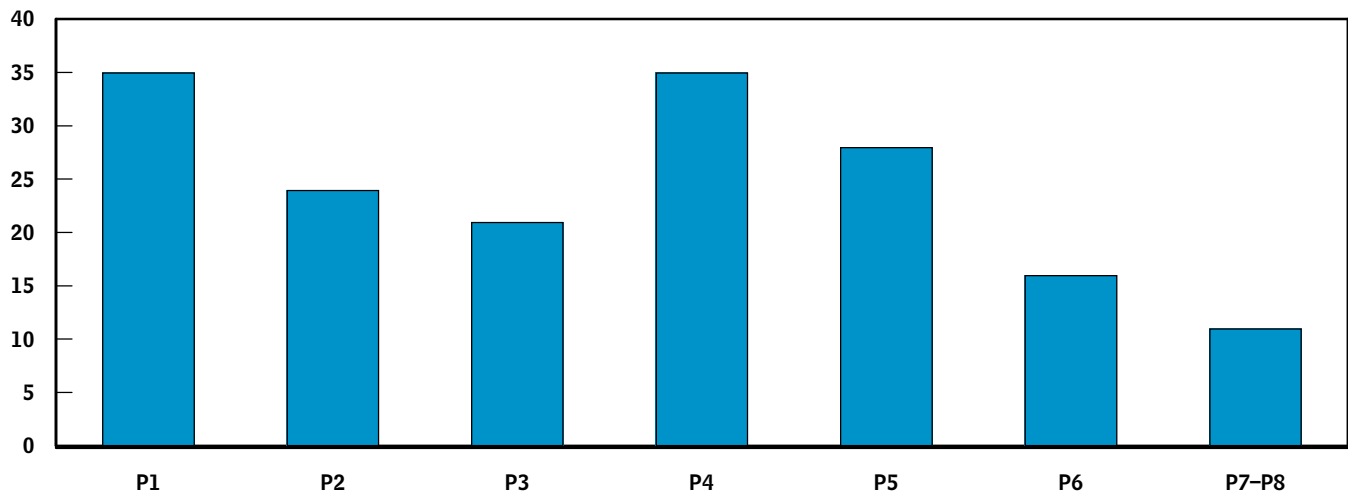
Using that measure, differences between priority groups remain but are less pronounced (see the right-hand panel of Figure 5 on page 18). Instead of a tenfold difference in

25. CBO obtained projections of future enrollment from VA. Those projections incorporate the assumption that VA maintains its current policies. See Appendix A for more information on how VA projects enrollment.

26. To derive the portion of non-OCO veterans who will enroll, CBO relies on projections by VA of the size of the veteran population for the next 20 years and of the priority groups to which those veterans are likely to be assigned. VA bases that information on historical data for disability and income status derived from the U.S. census and other sources. The portion of veterans who will enroll would be higher if the income restrictions on P8s were relaxed. By 2015, the fraction of eligible non-OCO veterans who chose to enroll would equal 39 percent if veterans whose income was 10 percent above the thresholds could enroll; that fraction would surpass 40 percent if veterans whose income was 30 percent above the thresholds could enroll.

Figure 4.**Estimated Rates of Reliance of Enrolled Veterans on VA's Health Care Services, by Priority Group, 2008**

(Percent)



Source: Congressional Budget Office based on data from the Department of Veterans Affairs (VA).

Notes: Reliance is the portion of a veteran's total health care (measured in dollars) that is provided by VA.

VA's enrollment system assigns veterans to one of eight priority groups (P1 through P8). Veterans with service-connected disabilities that are rated 50 percent or more disabling are in P1 (highest priority); those with higher income and no compensable service-connected disabilities are in P8 (lowest priority). For definitions of the priority groups, see Box 1 on page 4.

resources used per enrollee between P6s and P4s, the difference shrinks to roughly fivefold. Resources used for other priority groups (excluding P4s) are between 35 percent and 75 percent of those for P1 veterans. CBO assumes in both scenarios that the relative expenditures on veterans' health care will not change through the projection period.

In both scenarios, CBO adapted CMS's projections of growth in health care expenditures per capita for the general population to the pool of enrolled veterans.²⁷ CBO adjusted those projections to reflect differences in the technical and economic assumptions used by the two agencies, differences in the enrollee population specific to VA, and other relevant factors.

To capture the effect of aging on the growth in health care expenditures, CBO used its own projection, which

includes two effects. The larger effect is caused by a shift of VA's enrolled population from lower (less expensive) priority groups (such as P8) to higher (more expensive) groups (such as P1 through P3) as those enrollees age and their service-connected medical problems worsen. The smaller effect reflects the aging of enrollees within priority groups.

In Scenario 1, VA's per-enrollee expenditures for medical services for each priority group are assumed to grow at about the same rates as the national averages. CBO assumes that, on the basis of CMS data, the rate of growth of VA's health care expenditures per enrollee will be 3.7 percent for 2011, will increase to a 5.5 percent pace by 2016, and will stabilize at about that rate through 2020.

Under Scenario 2, CBO assumes a higher rate of growth in expenditures per enrollee for each priority group. Specifically, CBO applies growth rates for 2011 that are similar to those VA used in its budget planning for that year. Those rates are about 2.5 percentage points higher than the ones used in Scenario 1. Expenditures per enrollee are expected to rise more rapidly at VA than nationally in

27. Centers for Medicare and Medicaid Services, *National Health Expenditure Projections, 2009–2019*, www.cms.hhs.gov/nationalhealthexpenddata/downloads/proj2009.pdf. CBO used the published personal health care expenditure series and other unpublished data from CMS as the basis for projecting increases in VA's health care expenditures per enrollee. CBO used the rates for 2019 in projecting growth for 2020.

Box 3.**Health Care Coverage of Enrolled Veterans**

As of 2007, most veterans who were enrolled in the Department of Veterans Affairs' (VA's) health care system—nearly 80 percent—had other sources of health care available to them.¹ Nearly a third of veterans had access to employer-based health insurance or health care, and others had access to public sources for insurance coverage.² Veterans who are 65 or older and some who are disabled qualify for Medicare coverage, and some low-income veterans are eligible for Medicaid. In 2007, 55 percent of enrollees were covered by Medicare and 8 percent by Medicaid.

Whether veterans have other sources of insurance coverage—and what those sources are—varies

1. Department of Veterans Affairs, Veterans Health Administration, *2007 Survey of Veteran Enrollees' Health and Reliance Upon VA* (May 2008).
2. About 40 percent of veterans enrolled in VA's health care system are in the U.S. labor force, and 60 percent of them work full time. Many of the enrolled veterans who are not in the labor force may be retired (about 45 percent are over the age of 65) or in school.

according to which of the priority groups (P1 through P8) they are in (see the table at right). The higher-income groups (P7 and P8) were most likely to have non-VA coverage (90 percent in 2007). Those groups also had among the highest rates of private health insurance coverage and, because they had the largest percentage of enrollees over the age of 65 (more than 60 percent), were the most likely to be covered by Medicare. The lowest-income group (P5) had the fewest enrollees with other insurance coverage (68 percent in 2007); only 20 percent of P5 enrollees had employer-based coverage, and just 12 percent received Medicaid assistance.

Many veterans who have additional sources of coverage but enroll in the VA health care system use that system for at least a portion of their health care. For example, among veterans enrolled in both Medicare and VA's health care system, only about 30 percent relied solely on Medicare, and 15 percent relied solely on VA.

Continued

2011, in part because the cost of providing services is rising faster within VA than in the general population. For example, VA anticipated average nominal increases of 4.0 percent in the compensation of its medical and medical support employees in both 2010 and 2011; the increase in compensation for health services workers in private industry was about one-half that rate for the 12-month period ending June 30, 2010.²⁸ For the remainder of the projection period, CBO assumes that expenditures per enrollee for each priority group will grow at an annual rate that exceeds growth in Scenario 1

by 30 percent. (In other words, they grow about 30 percent faster than the rate CMS projects for the general population.) CBO assumes faster growth in use of services per enrollee and in medical price inflation for OCO and non-OCO enrollees in Scenario 2.

Projected Cost

CBO projects that the resources required to provide health care to all enrollees would increase from \$48 billion in 2010 to \$69 billion (in 2010 dollars) in 2020 under Scenario 1 and to \$85 billion in 2020 under Scenario 2 (see Table 2 on page 19 and Figure 6 on page 20). Both estimates are higher than CBO's baseline projection, under which appropriations for discretionary programs simply keep pace with inflation (see Box 4 on page 22).

Scenario 1. Adjusted for inflation, annual resources required to provide health care to all enrollees under

28. The private industry benchmark is total compensation for health care and social assistance workers from the employment cost index, which is published by the Bureau of Labor Statistics. See Department of Labor, Bureau of Labor Statistics, "Table 5: Employment Cost Index for Total Compensation, for Private Industry Workers, by Occupational Group and Industry," *Economic News Release* (July 30, 2010), www.bls.gov/news.release/eci.t05.htm.

Box 3.**Continued****Health Care Coverage of Enrolled Veterans****Percentage of Enrolled Veterans Who Reported Having Other Sources of Health Insurance Coverage, by Priority Group, 2007**

Priority Group	Medicare ^a			Medigap ^b	Medicaid ^c	TRICARE / TFL ^d	Private Insurance or HMO ^e	Any Non-VA Coverage
	Part B	Part D	Any					
P1	35	13	52	13	6	38	24	79
P2	24	11	35	11	5	37	39	82
P3	26	13	39	14	6	31	38	81
P4	42	26	67	19	19	5	12	72
P5	34	21	56	17	12	4	20	68
P6	15	7	22	7	4	18	56	79
P7 and P8	50	24	70	39	7	9	39	90
All Enrolled Veterans	37	19	55	22	8	17	31	79

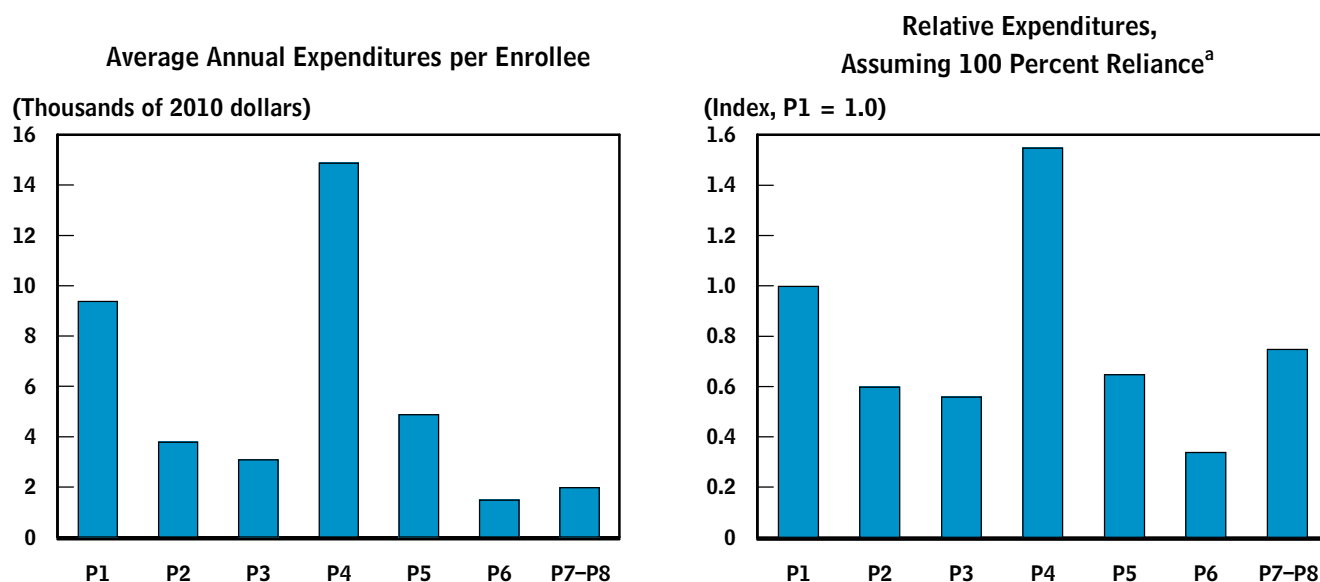
Source: Congressional Budget Office based on data from Department of Veterans Affairs, Veterans Health Administration, *2007 Survey of Veteran Enrollees' Health and Reliance Upon VA* (May 2008).

Note: For definitions of the priority group, see Box 1 on page 4.

- Most Medicare beneficiaries are automatically enrolled in Part A (hospital care) with no annual premium. Of veterans who participate in Medicare, most (about two-thirds) choose to enroll for a fee in Part B (medical insurance), which covers services provided by physicians and other practitioners, hospitals' outpatient departments, and suppliers of medical equipment. A much smaller proportion of Part A beneficiaries (about one-third) also choose to enroll in Part D (prescription drug coverage). Although for most priority groups, the proportions of veterans reporting, respectively, Part B coverage and Part D coverage coincidentally add to roughly the proportion reporting any Medicare coverage, there is no rigid mathematical relationship among those proportions because veterans enrolled in Part A may choose to enroll in either Part B or Part D individually, in both programs, or in neither program.
- Medigap plans are private supplemental insurance plans that provide additional coverage for Medicare beneficiaries. They may be purchased individually or provided by former employers as part of a retirement plan.
- Medicaid is the federal/state program in which the federal government provides funds to states to cover a portion of the costs they incur in paying health care providers serving low-income individuals.
- TRICARE is a Department of Defense (DoD) program that provides health care to active and retired military personnel and their eligible family members either at military treatment facilities or through purchased care contracts. TRICARE for Life (TFL) is a DoD program that provides supplemental coverage for military retirees and family members who are eligible for Medicare.
- A health maintenance organization (HMO) is a type of managed health care plan.

Scenario 1 would rise by about 45 percent, CBO estimates (see Figure 6 on page 20). Real growth in the annual resources required would be highest in the first five years of the projection period (reaching almost 5 percent in 2012), as OCO veterans and some additional, newly eligible P8 veterans enrolled; real growth would then decline slightly and, after 2016, would average 3 percent to 4 percent annually.

Assumptions about the growth of medical expenditures per enrollee, which outpaces that of general inflation, account for most of the increase through 2020 in CBO's projection of VA's potential costs. CBO estimates that the aging of the veteran population accounts for 1 percentage point of the annual growth in those costs in the early years of the projection period but for no more than 0.5 percentage points in later years.

Figure 5.**VA's Expenditures on Health Care Services per Enrollee, by Priority Group, 2008**

Source: Congressional Budget Office based on data from the Department of Veterans Affairs (VA).

Notes: Expenditures exclude those for medical research, nursing home care, and special programs and initiatives.

VA's enrollment system assigns veterans to one of eight priority groups (P1 through P8). Veterans with service-connected disabilities that are rated 50 percent or more disabling are in P1 (highest priority); those with higher income and no compensable service-connected disabilities are in P8 (lowest priority). For definitions of the priority groups, see Box 1 on page 4.

- a. Veterans in P1 are the reference group. Expenditures for all other groups are shown relative to the expenditures for P1 veterans. Calculations assume that enrollees depend on VA for all of their health care (100 percent reliance).

Under CBO's assumptions, the easing of the income restrictions on P8 enrollment in 2009 has little impact on total costs. The enrollees added since the restriction was eased in 2009 contribute \$1.2 billion, or less than 2 percent, to total costs for 2020. Similar to the current situation, most (about 85 percent) of the resources in 2020 would be used to treat veterans in the first six priority groups, and only about 15 percent would be devoted to the higher-income enrollees in P7 and P8. (Some of the increase in resources attributable to opening enrollment to more P8 veterans may be offset by decreases in other federal and nonfederal government spending, such as the Medicare and Medicaid programs, because some enrollees will switch part of their care from other health care options to VA. However, this report considers only the changes in VA's costs, not the impact on the entire federal budget or on national spending for health care.)

The resources required to treat OCO veterans would total \$5.4 billion by 2020 under Scenario 1, or less than 10 percent of all of VA's costs in this scenario. That

portion would grow after 2020, CBO estimates; at that time, OCO veterans would account for a larger share of enrollees, as service members who have served in overseas contingency operations separate from the military, veterans of earlier conflicts die, and OCO veterans develop age-related health conditions.

Scenario 2. Potential costs in this scenario reach nearly \$85 billion by 2020 (see Figure 6 on page 20). That amount is roughly \$15 billion—or 22 percent—higher than under Scenario 1 and about 75 percent more than the amount that has been provided for 2010.

VA's potential costs are very sensitive to the assumption about growth in expenditures per enrollee, which accounts for \$13 billion of the \$15 billion difference between the two scenarios in 2020. By contrast, CBO estimates that if the number of deployed troops and the growth of medical expenditures were held to the values assumed under Scenario 1 but the restriction on enrollment was eased so that veterans whose income exceeded

Table 2.**Projected Enrollment of Veterans for VA Health Care and the Potential Costs for VA to Provide Health Care Services to Them**

	Baseline	Scenario 1	Scenario 2
Projections for All Enrolled Veterans			
Number of Enrollees in 2020 (Millions)			
2011	n.a.	8.5	8.7
2020	n.a.	8.7	9.3
Potential VA Health Care Costs (Billions of 2010 dollars)			
2011	51	50	52
2016	54	62	70
2020	56	69	85
2011–2020	535	602	682
Projections for Enrolled Veterans of Overseas Contingency Operations			
Number of Enrollees			
In millions			
2011	n.a.	0.8	0.8
2020	n.a.	1.4	1.7
As a percentage of all enrolled veterans			
2011	n.a.	9	9
2020	n.a.	16	18
Potential VA Health Care Costs			
In billions of 2010 dollars			
2011	n.a.	2	3
2016	n.a.	4	6
2020	n.a.	5	8
2011–2020	n.a.	40	54
As a percentage of the potential health care costs for all enrolled veterans			
2011	n.a.	5	5
2016	n.a.	7	8
2020	n.a.	8	10
2011–2020	n.a.	7	8

Source: Congressional Budget Office.

Notes: The starting point for the cost projections in the two scenarios is the Department of Veterans Affairs' (VA's) appropriation for medical care and research in 2010. CBO's baseline budget projection, following Congressional rules, is based on VA's enacted advance appropriations for 2011 for medical services, medical support and compliance, and medical facilities and on VA's enacted appropriations for 2010 for all other medical accounts. Under those rules, CBO projects baseline spending in subsequent years by adjusting those appropriations by a forecast of future inflation—a weighted average of the gross domestic product (GDP) price index and the employment cost index for wages and salaries. For comparison with the two scenarios, those projections are converted to 2010 dollars by applying the GDP price index. Because CBO projects that wages and salaries will rise more rapidly than the GDP price index, the baseline projection increases slightly (in 2010 dollars) during the 2011–2020 period. See Table 1 on page 12 for the scenarios' underlying assumptions.

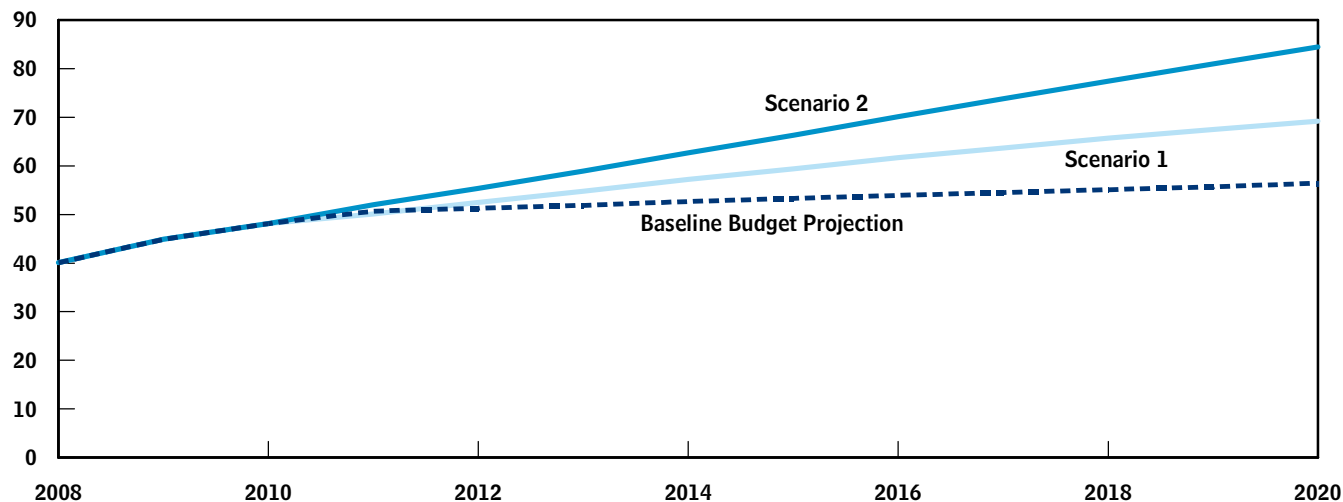
Overseas contingency operations include current military operations in Iraq and Afghanistan and related activities.

n.a. = not applicable.

- b. Projections of growth in medical expenditures for the general population are based on data from the Centers for Medicare and Medicaid Services and others.

Figure 6.**Potential Costs for VA to Provide Health Care Services to Enrolled Veterans**

(Billions of 2010 dollars)



Source: Congressional Budget Office.

Notes: The starting point for the projections in the two scenarios is the Department of Veterans Affairs' (VA's) appropriation for medical care and research in 2010. CBO's baseline budget projection, following Congressional rules, is based on VA's enacted advance appropriations for 2011 for medical services, medical support and compliance, and medical facilities and on VA's enacted appropriations for 2010 for all other medical accounts. Under those rules, CBO projects baseline spending in subsequent years by adjusting those appropriations by a forecast of future inflation—a weighted average of the gross domestic product (GDP) price index and the employment cost index for wages and salaries. For comparison with the two scenarios, those projections are converted to 2010 dollars by applying the GDP price index. Because CBO projects that wages and salaries will rise more rapidly than the GDP price index, the baseline projection increases slightly (in 2010 dollars) during the 2011–2020 period.

Compared with Scenario 1, under Scenario 2 CBO assumes higher enrollment of veterans of overseas contingency operations (currently including military operations in Iraq and Afghanistan and related activities), further easing of the restrictions on enrollment of higher-income veterans, and faster growth in medical expenditures per enrollee. See the text for a detailed explanation of the scenarios.

VA's thresholds by 30 percent or less could enroll, real costs in 2020 would increase by about \$1 billion. Easing the income restriction matters relatively little, because the additional P8 enrollees would have no compensable service-connected disabilities and would be more likely than veterans in other priority groups to have other health care options they might use rather than seeking care from VA.

Larger numbers of troops deployed to overseas contingency operations also explain little of the increase over the potential costs projected under Scenario 1. Using the same assumptions about the enrollment eligibility of P8 veterans and the growth in medical expenditures as under Scenario 1, the larger OCO deployments in Scenario 2 would add about \$1 billion.

Sensitivity Analysis. Two important assumptions that CBO adopted for both scenarios were that the number of enrolled non-OCO veterans (other than newly eligible P8 veterans) would remain largely stable, as would the veterans' rates of reliance on VA throughout the projection period. Most veterans use VA for less than half of their health care; the demand for VA's services would be significantly higher if that reliance increased.

CBO performed a sensitivity analysis to determine how its projections would be affected by changing its assumptions about veterans' reliance on VA for their health care. Specifically, CBO projected the increase in costs that would result from assuming that enrollees' reliance on VA rose on average by 10 percentage points, meaning that, on average, enrollees would receive about one-third of their care from VA, up from the current 23 percent. CBO

selected a reliance of one-third as being a reasonable upper bound because veterans in P1 (those who have service-connected conditions rated 50 percent or more disabling) and in P4 (those who have disabilities that are catastrophic but not service connected or who are house-bound) already rely on VA for that fraction of their annual medical care. All other assumptions were the same as in Scenario 1. In that case, although enrollment was unchanged, the greater reliance on VA would boost by nearly 45 percent the volume of services VA provides to veterans. Consequently, the costs for VA would grow by about that percentage, to just over \$100 billion by 2020, compared with the \$69 billion projected in Scenario 1.

CBO also performed a sensitivity analysis to determine how its projections would be affected by changing its assumptions about enrollment. Enrollment patterns are influenced by many factors, ranging from changes in VA's policies and outreach activities to changes in the economy. If those changes affected enrollment patterns equally across the board, the resources required to treat all enrolled veterans would also rise or fall by about the same percentage. However, the resource requirements associated with increased or decreased enrollment would vary significantly if certain groups of veterans enrolled disproportionately. In particular, increases in enrollment among the higher priority groups would boost costs more than would increases in enrollment among lower priority groups because the former groups consume more health care resources and rely more on VA for their health care. For example, out of a pool of about 10 million veterans who had not enrolled but who would probably be classified as P8 if they did so, each increment of 100,000 P8 enrollments above the number projected under Scenario 1 would add \$400 million, or 0.6 percent, in real costs for 2020, compared with \$1.8 billion, or 2.6 percent, for an equal increment in P1 enrollments (only about 100,000 of whom have not yet enrolled).

Potential Costs of Providing Health Care to Veterans of Overseas Contingency Operations

More than 1 million service members have deployed to overseas contingency operations since hostilities began in October 2001. As more of those personnel separate from military service and seek care at VA for war-related and other medical conditions, the resources VA will require over the next decade will be significantly affected. VA

expects to obligate almost \$2 billion in 2010 to provide health care to OCO veterans, a real increase of 34 percent above 2009 obligations (see Table 3 on page 24). In real terms, annual growth in VA's health care obligations for OCO veterans has exceeded 50 percent in three of the past four years. A large portion of that growth stems from rising enrollment and an increasing number of enrollees seeking care from VA; however, increases in the use of services per enrollee and in the rate of medical inflation above that of general inflation have also contributed. For example, use of ambulatory services, such as visits to physicians, grew by an annual average of more than 10 percent per OCO enrollee over the past several years.

In 2009, VA's average annual obligation per OCO patient was \$4,440 (in 2010 dollars), compared with \$8,600 per patient among all veterans. As a result, although OCO veterans accounted for 6 percent of all enrollees using VA's health care services in 2009, the resources devoted to their care consumed only 3 percent of VA's medical funding for that year. Their lower cost of care is largely attributable to their younger age; the amount of resources devoted to their care is similar to that of non-OCO veterans under the age of 45. As the OCO veterans age, CBO expects that their costs will be similar to those of other older veterans who use VA's health care services.

CBO separately projected the resources that VA would require to treat all OCO enrollees from 2011 to 2020. Those projections reflect the rapidly growing size of the OCO veteran population, the specific VA services those veterans use, and trends in health care costs throughout the economy. Under different assumptions about the number of troops deployed to overseas operations and about the growth in medical expenditures, CBO estimates that the potential costs would reach \$5 billion and \$8 billion in 2020 in Scenarios 1 and 2, respectively, compared with an anticipated \$2 billion for 2010.

Analytic Method

To project the potential costs of treating OCO veterans, CBO disaggregated the use of services into broad categories and, using detailed data on the projected growth in medical expenditures for different services, allowed OCO veterans' use of medical services and the cost of those services to vary over the projection period. That amount of detail is greater than what CBO used in its projections for non-OCO veterans (for whom the mix

Box 4.**Comparing the Scenarios with CBO's Baseline Budget Projections**

In this report, the Congressional Budget Office (CBO) presents three sets of projections of the future costs of the Department of Veterans Affairs' (VA's) health care programs. One is CBO's baseline budget projection; the others are two scenarios that use different assumptions and methods to make the projections. This box explains how CBO produces its baseline projections and then compares that method and the resulting projections with the ones CBO used in the two scenarios.

In preparing its baseline budget projection for VA health care, CBO follows rules established in the Balanced Budget and Emergency Deficit Control Act of 1985 for projecting spending that is controlled by annual appropriation acts. In making those projections, CBO assumes that the most recent year's funding is continued in each subsequent year, with adjustments for projected economywide inflation.¹ Specifically, the inflation rate is a weighted average of the gross domestic product (GDP) price index and the employment cost index for wages and salaries, with the weights reflecting the shares of personnel costs and other costs in that portion of the budget. That rate is applied to VA's total budget for medical care rather than on a per capita basis; that is, that baseline does not vary from year to year with changes in inflation specific to the health care sector, in the number of enrollees in VA's health care system, or in the characteristics of those enrollees and their corresponding use of services. It represents, simply, an extrapolation of the most recent appropriation over the projection period.

By contrast, the two scenarios reflect anticipated growth in health care expenditures and are applied on a per-enrollee basis rather than to the budget as a whole. (The growth in those expenditures is higher than the inflation rate used in the baseline projections.) The projections in those scenarios also

incorporate growth in enrollment and changes in the demographic profile of enrollees and their use of services.

Applying the baseline's methods and the price indexes results in slower projected growth in the total budget than is seen in the projections from the two scenarios. In CBO's baseline, VA's costs grow in real terms from \$48 billion in 2010 to \$56 billion by 2020.² By contrast, VA's costs in 2020 would total \$69 billion in real terms in Scenario 1 and \$85 billion in Scenario 2.

An implication of the results in both scenarios is that if VA's funding was held to the amount in CBO's baseline projection, the Secretary of Veterans Affairs would have to freeze enrollment or rescind the enrollment of veterans in several priority groups.³ In particular, VA would need to deny enrollees in the three lowest priority groups (P6, P7, and P8) access to care within the next 10 years. In Scenario 1, for example, VA would have to restrict enrollment of P8 and P7 veterans as early as 2012 and 2014, respectively. Even enrollees in P5—the lower-income enrollees—would face either a freeze on enrollment or other restrictions on access to VA's health care services by 2018 (see the figure below). If enrollment and health care costs grew at the higher rates assumed in Scenario 2, the need to impose restrictions on access would occur sooner and be even more severe if funding were provided at baseline levels.

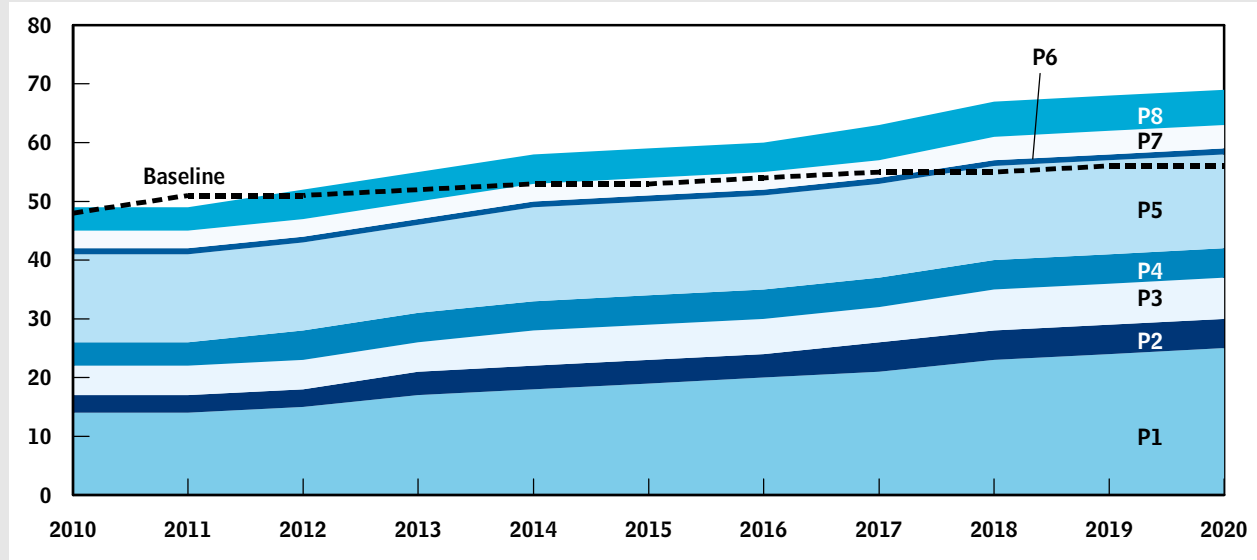
1. The starting point for CBO's baseline budget projection is VA's enacted advance appropriation for 2011 for medical services, medical support and compliance, and medical facilities; for all other medical accounts, the starting point is VA's enacted appropriation for 2010.

2. For comparison with the two scenarios, CBO applies the GDP price index to convert the annual baseline projections to 2010 dollars. Because CBO projects that wages and salaries will rise more rapidly than the GDP price index, and because the baseline is projected from the 2011 advance appropriation, the baseline projection increases in real terms through 2020.

3. Eligibility for VA's health care services is based primarily on a veteran's military service; in addition, VA operates an eight-tier priority system (P1 through P8) that establishes a veteran's eligibility and priority for using health care services. Veterans with the highest priority include those who have service-connected disabilities, low income, or both; those with the lowest priority have higher income and no compensable service-connected disabilities (that is, they have no medical condition that is disabling to the extent that VA provides compensation).

Box 4.**Continued****Comparing the Scenarios with CBO's Baseline Budget Projections****Potential Costs Under Scenario 1, by Priority Group,
Compared with CBO's Baseline Budget Projection**

(Billions of 2010 dollars)



Source: Congressional Budget Office.

Note: The starting point for the projection in Scenario 1 is the Department of Veterans Affairs' (VA's) budget for medical care and research in 2010. The starting point for CBO's baseline budget projection is VA's enacted advance appropriation for 2011 for medical services, medical support and compliance, and medical facilities and VA's enacted appropriation for 2010 for all other medical accounts.

of services is more stable). The evolution in the use and costs of medical services over time is especially important in Scenario 2, in which CBO assumes that the use of certain services grows faster among VA enrollees than among the general population. (See Appendix A for a further description of the method used.)

In Scenario 1, the number of service members deployed to overseas contingency operations drops to 30,000 in 2013 and stays at that number through 2020 (see Table 1 on page 12). The patterns of enrollment among OCO veterans and their use of services after they leave the military are assumed to be similar to those of recent years.

Scenario 2 represents a slower drawdown in the forces supporting such operations, to 60,000 by 2015. CBO assumes increases in the use of services and the growth of

medical prices above those in Scenario 1, with mental health services accounting for the largest increases in use.

Projected Enrollment, Use of Services, and Growth in Medical Expenditures per OCO Enrollee

Several factors—enrollment, use of VA's services, and the growth in health care expenditures per enrollee—influence the potential costs of treating OCO veterans. Enrollment and expenditures for certain health care services are growing much faster among those veterans than among veterans from earlier periods. Those factors, and CBO's assumptions, are discussed in this section.

Deployments and Separations from Active Service. CBO projected potential costs under two scenarios using differing assumptions about deployments and the effect on

Table 3.

Number of OCO Veterans Treated Each Year at VA and Average Annual Obligations per OCO Patient

	2005	2006	Actual 2007	2008	2009	Projected, 2010
Number of OCO Veterans Treated	101,000	155,000	206,000	261,000	333,000	382,000
Obligations ^a						
Millions of 2010 dollars	260	440	690	1,050	1,480	1,980
Percentage change from previous year	n.a.	69	57	52	41	34
Average Annual Obligations per OCO Patient (2010 dollars)	2,580	2,810	3,340	4,040	4,440	5,170

Sources: Congressional Budget Office based on the Department of Veterans Affairs' (VA's) budget submissions for 2007 through 2011.

Notes: Overseas contingency operations (OCO) include current military operations in Iraq and Afghanistan and related activities.

n.a. = not applicable.

- a. An obligation is a commitment that creates a legal liability on the part of the government to pay for goods and services ordered or received. Such payments may be made immediately or in the future.

VA's resource requirements. Both scenarios reflect the current troop surge to Afghanistan, the concurrent drawdown of troops from Iraq, and subsequent decreases in the number of service members deploying to overseas contingency operations around the world in future years. In Scenario 1, deployments are assumed to be lower throughout the projection period than in Scenario 2. In both scenarios, CBO assumes that the current rates of separation from military service, which are low by historical standards, will persist until the economy recovers and will then revert to the higher rates experienced in the beginning and middle of the past decade.

Under Scenario 1, CBO assumes that the number of deployed service members peaks at an average of approximately 220,000 active-duty, reserve, and National Guard personnel in theater in 2009; drops to 30,000 by 2013; and remains at that number thereafter (not necessarily in Iraq and Afghanistan).²⁹ Actual separations from military service for OCO troops since 2002, plus projected separations through 2020, would total 2.2 million personnel, CBO estimates.

For Scenario 2, CBO assumes that the deployed force is larger than the one in Scenario 1, peaking at an average of 235,000 troops for 2010 and dropping more slowly through 2014. The size of the deployed force declines to 60,000 at the beginning of 2015 and remains at that number thereafter. Separations of military personnel who deployed for overseas contingency operations from 2002 through 2020 would exceed 2.6 million.

Enrollment and Use of Services. Recent combat veterans are more than twice as likely to enroll as are non-OCO veterans and, of those enrolled, are as likely to use VA's health care services in a given year as are other enrollees. From 2005 through 2009, the annual number of OCO enrollees treated by VA grew rapidly, from 101,000 to 333,000—an average annual increase of 35 percent (see Table 3). Sixty percent of OCO enrollees used VA's health care services in 2009, a rate similar to that for all enrolled veterans.

Most service members (including reservists and members of the National Guard) who separate from active duty and then use VA's health services seek care for the first time shortly after they separate (see Figure 7).³⁰ For

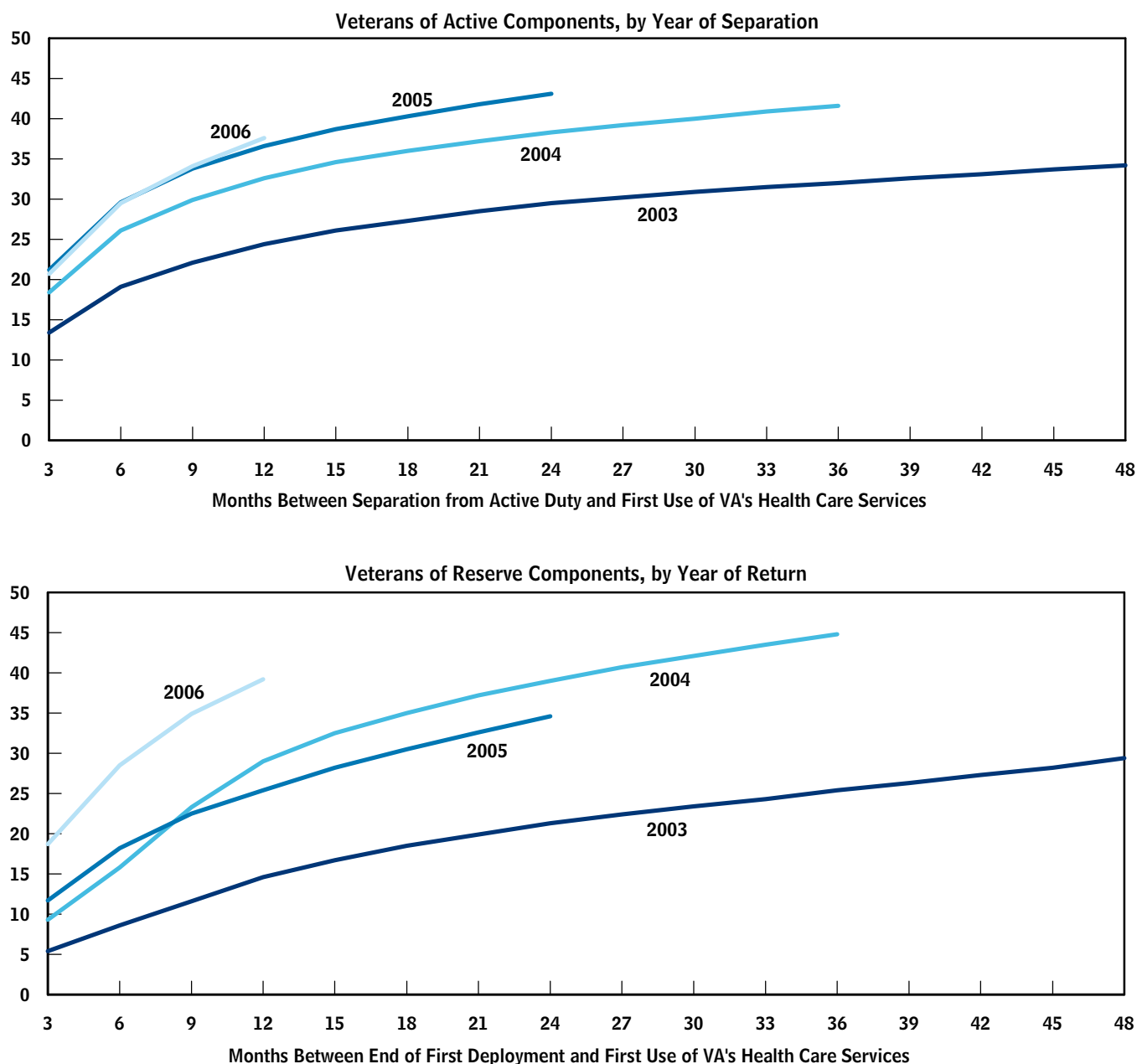
29. The two scenarios and associated budgetary outlays are described in Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2010 to 2020*, pp. 14–15. The total of 30,000 deployed service members excludes U.S. military personnel who are permanently based overseas (in locations such as South Korea or Okinawa, Japan) but are not engaged in contingency operations.

30. Data on the time between separating from active duty and first seeking care at VA are not available for reservists and members of the National Guard. However, data on their return from their first deployment (which approximates their separation from active duty) indicate a similar pattern; those personnel usually seek care at VA shortly after that time, if they seek care at all.

Figure 7.

Distribution of OCO Veterans by Time Between Separation from Active Duty and Their First Use of VA's Health Care Services

(Percent)



Source: Congressional Budget Office based on data from the Department of Veterans Affairs (VA) and the Department of Defense.

Notes: Data on time between separation from active duty and first use of VA's health care services are not available for reservists and members of the National Guard. However, data on their return from their first deployment (which approximates their separation from active duty) indicate a similar pattern; those personnel usually seek care at VA shortly after that time, if they seek care at all.

Overseas contingency operations (OCO) include military operations in Iraq and Afghanistan and related activities.

example, 18 percent of active-duty personnel who separated from the military in 2004 used those services within 3 months of separation, and an additional 14 percent did so within the next 9 months. In the second year after separation, only 6 percent of the cohort became new users of VA's services, and 3 percent sought care for the first time in the 24 to 36 months after separation. The two-year window of eligibility for combat veterans to enroll regardless of income or disability that was in effect at that time does not appear to have substantially limited access to VA's medical services; most veterans who enroll do so soon after separation. In addition, the proportion of veterans who seek care at VA soon after separation has generally been increasing with each successive group of service members who separate from military service. That trend may indicate that more veterans are aware of the services the department provides or are in greater need of its services.

Under both scenarios CBO assumes that the time OCO veterans take to enroll after separation from active-duty service remains stable over the projection period and that the proportion of newly separated veterans who enroll continues to grow early in the projection period but quickly levels off. (In a later section, CBO presents a sensitivity analysis of those assumptions.) Because the number of service members who are assumed to deploy varies between the two scenarios, the number of new enrollees also differs. The cumulative number of veterans who enroll after returning from overseas contingency operations would grow from about 550,000 in 2009 to 1.4 million in 2020 in Scenario 1 and to 1.7 million in Scenario 2.

VA reports, and CBO projects, veterans' use of seven major categories of service: ambulatory care (for example, outpatient visits and pathology and laboratory services), inpatient hospital care, pharmacy services (dispensing of pharmaceuticals, over-the-counter drugs, and related supplies), other medical services (aids and equipment), outpatient programs for mental health care, special residential care programs (such as rehabilitation for the blind or residential psychiatric treatment), and dental procedures. As in VA's overall enrollee population, the largest component of costs among OCO veterans is ambulatory care, followed by inpatient hospital care and pharmacy services. (Although fewer than 27,000 OCO veterans, or 5 percent of all OCO enrollees, have been hospitalized in a VA facility since 2002, the high cost of inpatient care makes it one of the largest components of costs.)

Use of VA's medical services by OCO veterans is greatest in the months immediately after they enroll and then declines sharply in the next several months for most categories of service. The generally downward trend in use of services within each new group of enrollees has several possible explanations. Some veterans who find civilian employment or, in the case of reservists, who return to work, may prefer to use private health care providers for most or all of their care, particularly if they do not have any service-connected injuries or conditions. Other veterans may turn to private sources of care after receiving a health screening or completing treatment for a medical condition.

VA's historical data indicate that rates of use of services typically stabilize after 12 months of enrollment. That constancy suggests that it is likely that no material change in use of services occurred after eligibility was extended from two years to five years for veterans to receive free care for conditions that could be combat related. (When a combat veteran's special eligibility period ends, the veteran continues to have access to health care services, although perhaps in a lower priority group with applicable copayments.)³¹

CBO assumes, under both scenarios, that the pattern of use of services observed in the years after enrollment remains the same over the projection period. Any increase in the use of services attributable to the aging of the population is reflected in those data and consequently in the projections. The scenarios, however, involve different assumptions about the overall growth in the use of services per enrollee.

Expenditures per OCO Enrollee. CBO follows the same general assumptions about the growth in expenditures per OCO enrollee as it did for other VA enrollees. In both scenarios, CBO applies detailed data, which are based on CMS's projections of rates of expenditure growth for various categories of medical services, to corresponding categories within the VA program. CBO then adjusts those estimates to reflect differences in the technical and economic assumptions used by the two agencies, differences in the enrollee population specific to

31. See Department of Veterans Affairs, *Combat Veteran Eligibility*, VA Health Care Fact Sheet 16-4 (September 2010), www4.va.gov/healtheligibility/Library/pubs/CombatVet/CombatVet.pdf.

VA, and other relevant factors.³² Specifically, CBO eliminates the growth in health care expenditures that CMS attributes to the aging of the U.S. population (about 0.5 percentage points annually) and, instead, incorporates the effect of aging in the assumed use of services in the years after enrollment.

Under Scenario 1, CBO assumes that VA's health care expenditures per OCO enrollee for the seven major categories of service grow at about the same rates as the national averages for those services. CMS projects that the growth in expenditures for individual types of services will generally rise through the middle of the decade and then stabilize or decline slightly and that the growth rates in any given year will vary by type of service. For example, per capita expenditures for visits to physicians are expected to grow 3.4 percent in 2011 (in nominal terms) compared with a 4.7 percent increase for prescription drug expenditures.³³

Under Scenario 2, CBO projects a higher rate of growth in expenditures per OCO enrollee than under Scenario 1. Specifically, CBO applies assumptions about the growth in use for each of the seven broad categories of service and their unit costs for 2011 that are similar to those VA used in its budget planning for that year. Higher rates of use of services may reflect, in part, VA's outreach efforts and special initiatives. For the remainder of the projection period, CBO generally assumes that expenditures per OCO enrollee grow at an annual rate that is 30 percent higher than the rate in Scenario 1.

32. The mix of services within each major category of services provided to the general population may differ from that provided to veterans by VA (for example, VA's inpatient care may be composed of relatively more psychiatric stays), but CBO assumes that the categorywide rates of growth are similar.

33. These are unpublished figures from CMS that assume that Medicare physician payments would stay constant in 2010. The rates CMS published on its Web site assume, by contrast, that physician payment rates would be cut by 21.3 percent for that year. That cut was avoided when the payment rates were temporarily frozen by the Continuing Extension Act of 2010 (P.L. 111-157), which was enacted on April 15, 2010. That action was later overridden by the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (P.L. 111-192), which was enacted on June 25, 2010, and granted a 2.2 percent increase in payment rates. Those higher rates prevailed for just over one quarter of fiscal year 2010.

Because VA expects that the largest growth will occur in visits per enrollee to specialized psychiatric programs—16 percent in 2010, falling to 10 percent in 2012—CBO adjusts the growth in the use of outpatient psychiatric programs (as measured by visits per enrollee) upward in 2012 to more closely reflect those expectations. CBO assumes that, by 2014, the growth slows to a rate that is 30 percent higher than in Scenario 1. Those programs include treatment programs for veterans with PTSD. VA treated nearly 60,000 OCO veterans for that disorder in 2008 and projects that the number will continue to grow substantially through 2020. Accurately estimating the number of enrollees who will be treated for PTSD in the longer term is difficult, however; it depends on many factors that change over time, including the deployment of troops, the intensity of battle, the resiliency of the veterans, the effectiveness of treatment, the extent of VA's outreach efforts, and the willingness of veterans who require treatment to seek it.

Projected Cost

The costs that would be incurred to treat OCO veterans under the two scenarios are presented in this section. Both scenarios reflect plausible but different assumptions about how many service members will deploy to overseas contingency operations and about growth in medical expenditures per enrollee. (The relaxation of the restrictions on P8 enrollment does not affect OCO veterans because they remain enrolled after their special eligibility ends.)

Scenario 1. Under the assumption that deployed troop strength drops to 30,000 by 2013, CBO estimates that VA will have enrolled 1.4 million OCO veterans and treated a total of 1.3 million of them from the beginning of hostilities through 2020. The real resources required to provide care to those veterans would more than double, rising from \$2 billion in 2010 to roughly \$5 billion in 2020 (see Figure 8), for a cumulative total of \$40 billion.³⁴ By comparison, CBO projects that the total resources needed to treat other VA enrollees would rise by almost 40 percent, from \$46 billion in 2010 to \$64 billion in 2020.

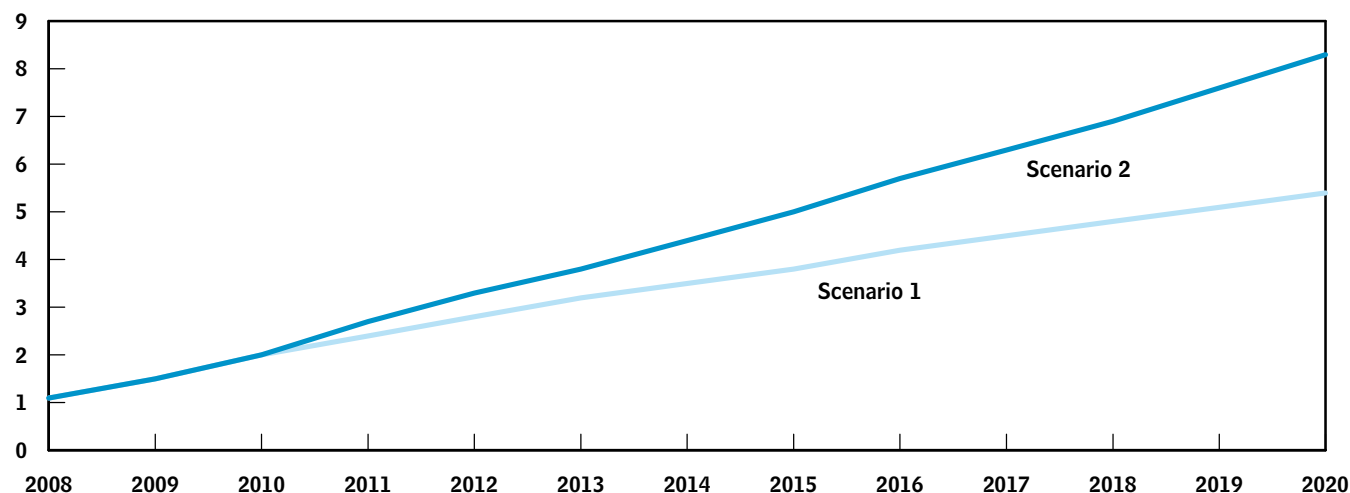
The largest growth would occur in 2011 and 2012, when potential costs are projected to increase by 15 percent or

34. Including the funding devoted to those veterans from 2002 to 2010 would boost that amount to \$46 billion.

Figure 8.

Potential Costs for VA to Provide Health Care Services to Enrolled Veterans of Overseas Contingency Operations

(Billions of 2010 dollars)



Source: Congressional Budget Office.

Notes: The starting point for the projections in the two scenarios is the Department of Veterans Affairs' (VA's) estimate of obligations in 2010 to provide health care services to veterans of overseas contingency operations (currently including military operations in Iraq and Afghanistan and related activities).

Compared with Scenario 1, under Scenario 2 CBO assumes higher enrollment of veterans of overseas contingency operations and faster growth in medical expenditures per enrollee. See the text for a detailed explanation of the scenarios.

more annually. After that, the number of new enrollees in any given year would begin to fall. Partly because enrollees incur the highest costs in the year after they enroll, annual costs would begin to grow at a slower rate. By 2015, annual real increases would be less than 10 percent and would fall to about 6 percent by the end of the projection period.

Rising enrollment over the projection period is responsible for a large portion of the increase in the projected resources required to treat OCO veterans under Scenario 1. Treating the additional 720,000 OCO veterans projected to enroll between 2011 and 2020 would consume nearly \$3 billion, or roughly half of the costs for OCO veterans in 2020, CBO estimates; the 670,000 OCO veterans expected to enroll before 2011 would account for the rest.

The aging of the OCO population is likely to have only a small effect on costs. According to data from VA, nearly 70 percent of OCO veterans who use VA's health care services are under the age of 40, and all but 1 percent are under the age of 60. By contrast, about 45 percent of

the U.S. population is over 40 years old, and almost 20 percent is at least 60 years old.³⁵ Because a large fraction of the OCO veteran population is relatively young—in an age group in which medical costs are largely stable—their aging over the decade will probably have a small effect on the resources required per OCO enrollee in 2020.³⁶

Veterans of military operations probably seek more medical services than do other veterans, for several

35. About 45 percent of all enrolled veterans are 65 or older. The statistics about aging are CBO's calculations based on data from the Census Bureau's Population Division.

36. See E. Meira and others as cited in Uwe Reinhardt, "Does the Aging of the Population Really Drive the Demand for Health Care?" *Health Affairs*, vol. 22, no. 6 (2003), p. 28. That research indicates that annual medical costs for the U.S. population between the ages of 35 and 44 are similar to costs for people ages 25 to 34. Costs for people ages 44 to 54 are about 40 percent higher than for those between 25 and 34. The largest increases occur after age 55. Compared with costs for 25-year-olds, costs are twice as high for people ages 55 to 64 and three times as high for those ages 65 to 74.

reasons. Some may have battle-related injuries, and others may develop medical conditions from the harsh environment. Still others may be more aware of their VA benefits. The estimated costs under both scenarios include the total resources that may be used to treat OCO veterans for conditions that veterans incurred while deployed and conditions that are unrelated to the deployment.

In addition to estimating the potential costs for OCO veterans, CBO has also investigated how much of the expenditures for treating them are related to their deployments to contingency operations and would not have been incurred otherwise. Those estimates should not include the costs associated with treating conditions that veterans developed while deployed but would have developed even if they had remained in the United States (for example, normal age- or training-related injuries). CBO has little direct data on that question; however, VA has published data on enrollment and the number of ambulatory visits for veterans who deployed to the first Gulf War (August 1990 through July 1991) and for veterans who served during the same period but did not deploy. The experience of the latter group can be used to estimate the rates at which Gulf War veterans might have used VA's health care services had they not deployed.

To estimate the use of services attributable to deployment, CBO subtracted the use of services by veterans who had not deployed from the larger volume used by veterans who had deployed to that earlier conflict. CBO estimates that just over one-half of service members who deployed to the first Gulf War would have used VA's health care services even if they had not served in theater but that those users would have made 10 percent fewer ambulatory visits, on average, through 2004 had they not deployed. Assuming that similar patterns hold true for OCO enrollees, CBO estimates that of the \$46 billion in projected costs over the 2002–2020 period for OCO veterans under Scenario 1, about \$25 billion can be specifically attributed to their deployments.

Scenario 2. Under the assumption that a larger force will deploy and that medical expenditures per enrollee will grow faster than in Scenario 1, CBO estimates that the resources VA would need to treat OCO veterans in 2020 are substantially higher in Scenario 2 than in Scenario 1—\$8 billion (in 2010 dollars) compared with \$5 billion (see Figure 8). As in Scenario 1, the largest growth in resource requirements would occur early in the projection period, rising by more than 35 percent in 2011 and by

20 percent in 2012. After that, annual growth slows—to 9 percent by 2020. Costs over 10 years would total \$54 billion (in 2010 dollars) compared with \$40 billion in Scenario 1.

The faster growth in expenditures per enrollee in Scenario 2 accounts for most of the difference in resource requirements between the two scenarios for 2020. Holding deployments to the smaller size assumed in Scenario 1, higher expenditures per enrollee alone would result in potential costs of \$7 billion (in 2010 dollars) for 2020, an increase of \$2 billion above the requirements in Scenario 1.

The larger number of service members deployed to overseas contingency operations in Scenario 2 accounts for little of the increase in resource requirements. Assuming the same growth in medical expenditures as in Scenario 1, the higher number of troops deployed in Scenario 2 would cost an additional \$1 billion compared with Scenario 1. Although the number of military personnel deployed to overseas contingency operations for the 10-year period is twice that in Scenario 1, the projected health care costs differ by only about 12 percent as a result for the same period.

Two factors account for the nonproportional relationship between deployments and costs. First, although the number of personnel deployed at a point in time doubles in Scenario 2, the total number of personnel (in the active and reserve components) who separated from active duty for the 10-year period increases by 45 percent in Scenario 2; it does not double because most of the service members who will ever deploy in the current conflicts are expected to have done so before 2011. Many of them will separate during the 10-year projection period and are therefore eligible for VA's health care services under both scenarios. That common group of separations is much larger than the difference between the two scenarios in the number of separations. Second, the difference in separations is attenuated because—like all OCO veterans—many of the additional service members who separate in Scenario 2 are not likely to seek care at VA within the projection period; indeed, many may choose not to enroll.³⁷ Consequently, VA would not incur costs to treat many of the additional veterans who separate during the projection period.

37. Only about one-third of all veterans are currently enrolled.

Sensitivity Analysis. Two important assumptions CBO adopted for both scenarios were that the percentage of OCO veterans seeking treatment at VA and the time between separation and enrollment would be stable through the projection period. Those assumptions, however, are uncertain. VA's policies and outreach efforts or external factors could influence how many OCO veterans would seek care at VA and when they would do so.

To see how sensitive its projections are to assumptions about enrollment, CBO assumed instead that the share of OCO veterans separating in 2011 or later and enrolling would increase by 10 percentage points and that they would enroll within three months of separation; more

than two-thirds of those OCO veterans would eventually enroll under that assumption.³⁸ All other assumptions were the same as in Scenario 1. In that case, the number of OCO enrollees would rise to 1.5 million from 1.4 million in Scenario 1, an increase of 7 percent. The corresponding potential cost to treat OCO enrollees would be nearly \$6 billion in 2020, or just a little higher than in Scenario 1, and \$42 billion over the projection period, or \$2 billion (5 percent) higher than in Scenario 1.

38. CBO selected 10 percentage points as a reasonable variation in the proportion of OCO veterans who enroll, in light of the differences in the rates at which they seek care (see Figure 7 on page 25).

Procedures for Projecting VA's Potential Costs

This Congressional Budget Office (CBO) report projects the potential costs the Department of Veterans Affairs (VA) might incur to provide health care services to enrolled veterans for the next 10 years, 2011 through 2020. It makes those projections for two groups of veterans: those who have served in the ongoing overseas contingency operations (OCO) in Iraq, Afghanistan, and related activities and those who have not (referred to as non-OCO veterans).

CBO used different methods for projecting VA's costs for non-OCO and OCO veterans, in part because the enrollment of non-OCO veterans and the mix of services they use typically change little from year to year compared with that of their OCO counterparts. Because non-OCO veterans' use of services and the resources devoted to them differ significantly by priority group, CBO projected the total costs by priority group. CBO projected the number of enrollees on the basis of VA's enrollment projections and assumed that the mix of services within each priority group will remain the same over the projection period.¹

For the OCO veterans, CBO accounted for the anticipated rapid increase in enrollment by projecting their separation from active-duty service and their subsequent enrollment. To reflect the changes in their use of services over time, CBO projected their use of the seven major categories of medical services that VA provides.

Projecting Costs for Non-OCO Veterans

Substantial differences exist between priority groups in the use of VA's health services, the extent to which enrollees rely on VA for health care, and the annual expenditures per enrollee. To take advantage of that information and to add the capability to predict changes in the enrollment of non-OCO veterans within priority groups, CBO projected the use of health care services and potential costs separately for each of the eight priority groups.

As the starting point for its projections, CBO used the 2010 appropriations for VA's medical program (subtracting the resources estimated to be used for OCO veterans). CBO then applied VA's projections of annual enrollment (with some adjustments). Those projections are derived from VA's current and historical data on enrollment, mortality rates of enrollees, and other demographic information about enrollees and are reported by priority group.

Underlying the projections of enrollment is the assumption that a fixed percentage of veterans who have not enrolled will do so each year.² VA allocates projected new enrollees among the priority groups to which they would most likely be assigned and adjusts projected enrollment for recent policy changes or shifts in enrollment. For instance, the projections include changes in enrollment from expected increases in copayments that are determined by regulation. VA further adjusts future enrollment rates and numbers within geographic localities downward if its initial projected enrollment approaches

1. VA operates an eight-tier priority system that establishes a veteran's eligibility and priority for using health care services. Factors such as the presence and extent of disability and a veteran's income determine placement among the eight priority groups. For a detailed description of the eight priority groups, see Box 1 on page 4.

2. That assumption is consistent with the statistical analysis by an actuarial firm with which VA contracted when developing its model for projecting enrollment in its health care program and its funding needs. See Department of Veterans Affairs, *FY04 VA Health Care Projection Model Final Model Run Reports*, vol. II, Appendix C, "Enrollment Rates Analysis Report" (prepared by Milliman USA and CACI, November 2003). CBO did not assess the accuracy of VA's enrollment projections.

the total number of veterans living in those regions—the notion being that not all eligible veterans will enroll.

CBO built up the cost projection for each of the eight priority groups from separate estimates of use of services (measured as full-time equivalent users) and the annual cost per user in each group. The number of users was computed as the number of non-OCO enrollees times the reliance of veterans within a priority group on VA; reliance is the portion of veterans' costs incurred by VA as a percentage of their total annual health care costs provided by any source.³ That methodology enables CBO to separately adjust for future changes in reliance and total cost per user by priority group. The annual cost per user was estimated from historical data specifically for veterans in each priority group and was then inflated by the same annual factors for each priority group. CBO adapted its estimates of growth in health care expenditures from data developed by the Centers for Medicare and Medicaid Services (CMS).

Projecting Costs for OCO Veterans

Enrollment among OCO veterans has been growing rapidly since service members who deployed to the current overseas contingency operations began to separate from active-duty service. Those veterans enroll in VA's health care system at higher rates than do non-OCO veterans, and some of them (for example, reservists who deploy) may not have been eligible for VA's services otherwise. Accurately estimating the annual enrollment of OCO veterans and the annual costs of treating them requires a different estimation procedure than the one used for non-OCO veterans. CBO's projections for OCO veterans therefore reflect the growing number of veterans who will be eligible to use VA's medical services, anticipated changes in veterans' use of services, and economywide increases in medical expenditures per capita. CBO's projections start with the obligations VA expects to devote to OCO veterans in 2010.

To project the number of new enrollees in a given year, CBO first estimated the annual number of service

members who separate from military service after their deployment to overseas contingency operations. To do that, CBO estimated annual separation rates for 2010 and for 10 years thereafter among service members who have returned (or will return) from deployment since the beginning of hostilities through 2020. Those rates are based on historical separation rates of service members who deployed to overseas contingency operations from 2002 through 2007, which the Department of Defense provided to CBO. CBO applied those annual historical rates to the actual or projected number of service members returning from deployment in a given year, until all individuals in that cohort had separated from active duty. Some members serving in the active components will not separate until they have accrued 20 years or more of additional military service.⁴ Reservists who end their deployment in a given year, however, are assumed to separate from active service and thus be eligible to enroll in that year (although they may remain affiliated with the reserves and deploy again). To avoid double-counting the number of reservists who become eligible, CBO considered only separations associated with a reservist's first deployment.

Using historical data from VA on the time between separation from active-duty service and enrollment, CBO estimated how many service members who separate in a given year will enroll in that year or subsequent years.⁵ CBO estimated OCO veterans' use of seven broad categories of services in each year after enrollment, assuming that past trends in use of services continue into the

3. VA calculates reliance as its expenditures on veterans' health care divided by its estimate of the total expenditures on health care devoted to those veterans, including costs paid by the public sector, by private insurance, or out of pocket by the veterans.

4. The number of OCO veterans who are expected to be retirees increases over the projection period. By the end of the period, almost 15 percent of OCO separations from the active component are military retirees, compared with about 10 percent at the beginning of the period. Presumably, those retirees, who may also use the Department of Defense's health care system (known as TRICARE), are less likely than other veterans to enroll and to use VA's services. CBO does not account for differences in use of services between retirees and other veterans but anticipates that the overstatement of potential costs would be minimal.

5. Data on time between separation from active duty and first use of VA's services are not available for reservists and members of the National Guard. However, data on their return from their first deployment (which approximates their separation from active duty) indicate a similar pattern; those personnel usually seek care at VA facilities shortly after that time, if they seek VA care at all.

future.⁶ That approach allows the mix of services to change as each new cohort of enrollees ages. Some veterans may develop conditions that do not present symptoms or require medical attention until several years after the deployment. Because the projection is based on historical data that reflect the enrollment of veterans or use of services for no more than six years after deployment, it may not capture those ailments or their attendant costs.⁷

6. Those categories are ambulatory care (for example, outpatient visits and pathology and laboratory services), inpatient hospital care, pharmacy services (dispensing of pharmaceuticals, over-the-counter drugs, and related supplies), other medical services (the provision of aids and equipment), outpatient programs for mental health care, special residential care programs (such as rehabilitation for the blind or residential psychiatric treatment), and dental procedures.

On the basis of the use of health care services in a fiscal year projected by CMS, CBO then applied projections of per capita growth in medical expenditures to the seven categories of services and estimated a stream of VA's annual potential costs.⁸

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7. CBO estimates the enrollment rates more than six years after separating from military service using the patterns of Gulf War veterans; however, insufficient data are available to estimate the annual use of services associated with conditions that do not appear until more than six years after enrollment. CBO anticipates that the omission of costs would have a negligible impact on the 10-year costs presented in this paper but might have a greater impact on costs in the longer term.
8. Although CBO estimates the cumulative number of veterans treated at VA, the projections of expenditures are based on the enrollees' use of each broad category of medical services. The number of patients in a given year and the typical bundle of services a patient uses are not projected directly.

Differences in Veterans' Use of VA's Health Care Services

The extent to which enrollees use the health care services provided by the Department of Veterans Affairs (VA) varies substantially, both between different groups of veterans and, for individual veterans, by the number of months since their enrollment. The most disabled veterans and those who have low income make the greatest use of services, and higher-income veterans and veterans of overseas contingency operations (OCO) use fewer services.¹ Use of services, which is measured in this appendix on a per-enrollee basis, tends to be highest at the time veterans enroll, although that is not true for all medical services.

Use of Services by All Enrollees

The Department of Veterans Affairs has a system of eight enrollment categories, or priority groups, to establish veterans' eligibility and priority for care. Veterans who have service-connected disabilities (priority groups 1 through 3, or P1 through P3) have the highest priority; higher-income veterans who have no compensable service-connected disabilities (that is, no medical condition that is disabling to a degree that VA provides compensation) have the lowest priority (P8).

Variation in the use of services among those priority groups is pronounced. Several factors account for that variation. Veterans who have disabilities probably require more services, all else being equal. In addition, not all veterans face the same out-of-pocket costs. Typically, enrollees considered by VA to be 50 percent or more disabled and enrollees who are being treated only for

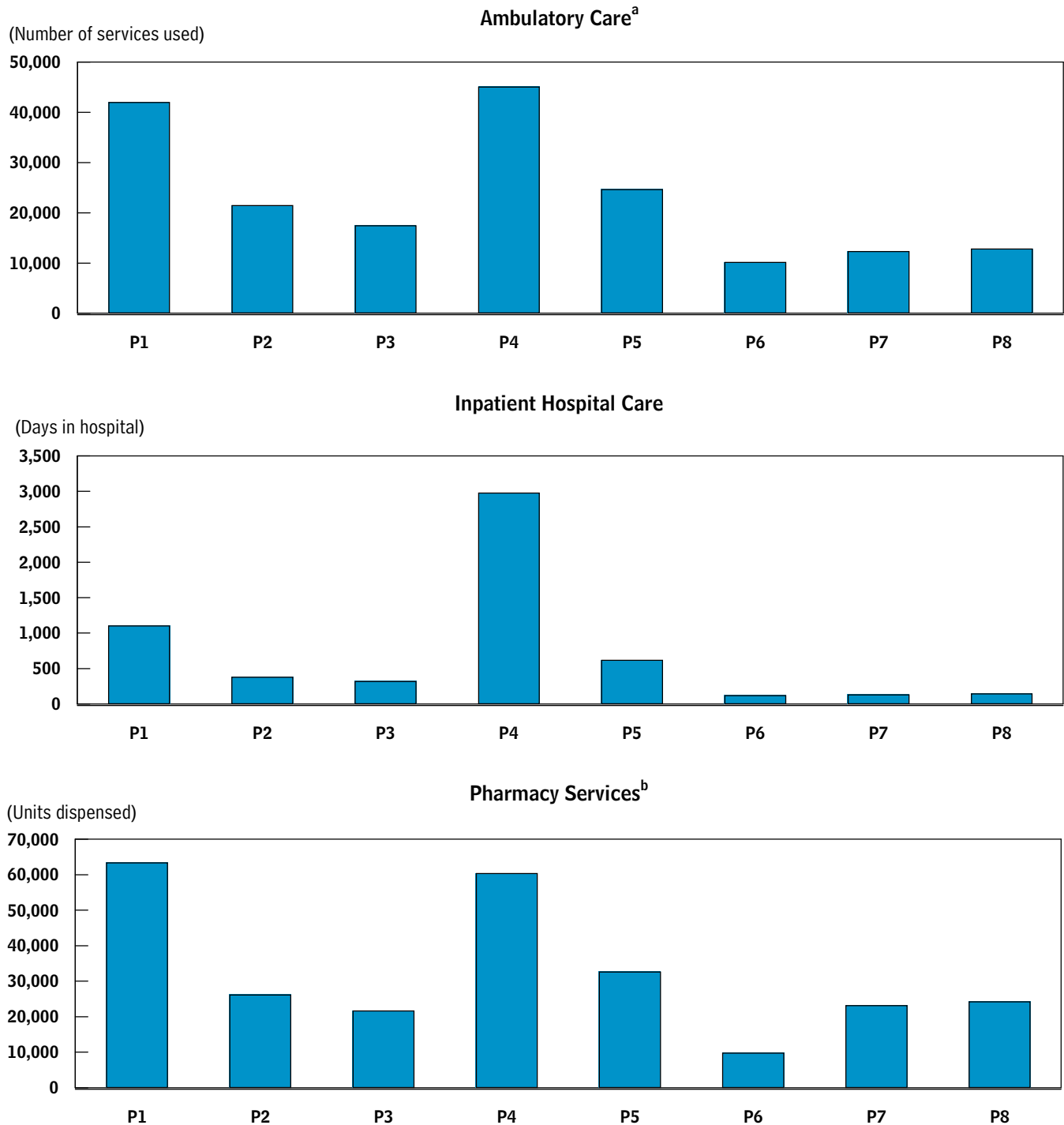
service-connected medical conditions pay no out-of-pocket costs, but most other enrollees may have a copayment associated with their treatment.

Enrollees in P1 (veterans who have service-connected conditions rated 50 percent or more disabling) and P4 (veterans who have disabilities that are catastrophic but not service connected or who are housebound) use substantially more medical services than do other enrollees for each of the seven major categories of service for which VA reports unit costs and number of services used. P4 veterans make the heaviest use per enrollee of five of the seven categories—ambulatory care, inpatient hospital care, other medical services (the provision of aids and equipment), outpatient programs for mental health care, and special residential care programs—and rank second in use per enrollee of the other two categories (pharmacy services and dental procedures).

As shown in Figure B-1, enrollees who are rated 50 percent or more disabled (those in P1) use at least two and a half times more services per enrollee in the three largest components of expenditures (ambulatory care, inpatient hospital care, and pharmacy services) than do higher-income veterans without compensable service-connected disorders (those in P7 and P8).² Only P6 veterans—most of whom are recent combat veterans who have not received disability ratings and are typically much younger than VA's overall population—make less use of VA's services than do P7 and P8 veterans.

1. Overseas contingency operations include current military operations in Iraq and Afghanistan and related activities.

2. Of the seven categories of services, ambulatory care accounted for the largest component of expenditures (\$15 billion in 2008), followed by inpatient hospital care (\$9 billion) and pharmacy services (\$5 billion).

Figure B-1.**Use of VA's Health Care Services per 1,000 Enrollees, by Priority Group**

Source: Congressional Budget Office based on data from the Department of Veterans Affairs (VA).

Note: VA's enrollment system assigns veterans to one of eight priority groups (P1 through P8). Veterans with service-connected disabilities that are rated 50 percent or more disabling are in P1 (highest priority); those with higher income and no compensable service-connected disabilities are in P8 (lowest priority). For definitions of the priority groups, see Box 1 on page 4.

a. Includes the number of outpatient visits and other services, such as radiology and pathology services.

b. Includes the dispensing of pharmaceuticals, over-the-counter drugs, and related supplies.

Enrollees' use of services not only differs among various groups of veterans but also changes over the months after enrollment, typically declining over the first year of enrollment (see Figure B-2). For example, ambulatory care and inpatient hospital care show steady declines in use. By the second year after enrollment, the use of those two services drops to roughly one-half and one-third, respectively, of that experienced initially. Most services within those categories, such as pathology-related services and office and urgent care visits, follow a similar pattern.

Enrollees' use of pharmacy services follows a somewhat different pattern than that for ambulatory care and inpatient hospital care (see Figure B-2). The number of pharmacy services per 1,000 enrolled veterans shows an early spike as veterans schedule and receive their initial visits after enrolling, then a steady increase over the first 60 months after enrollment. Veterans' share of the cost of prescription medication (a maximum copayment of \$9 for non-service-connected conditions) is lower than that for enrollees in many private health insurance plans, and veterans may therefore rely more on VA for that service.

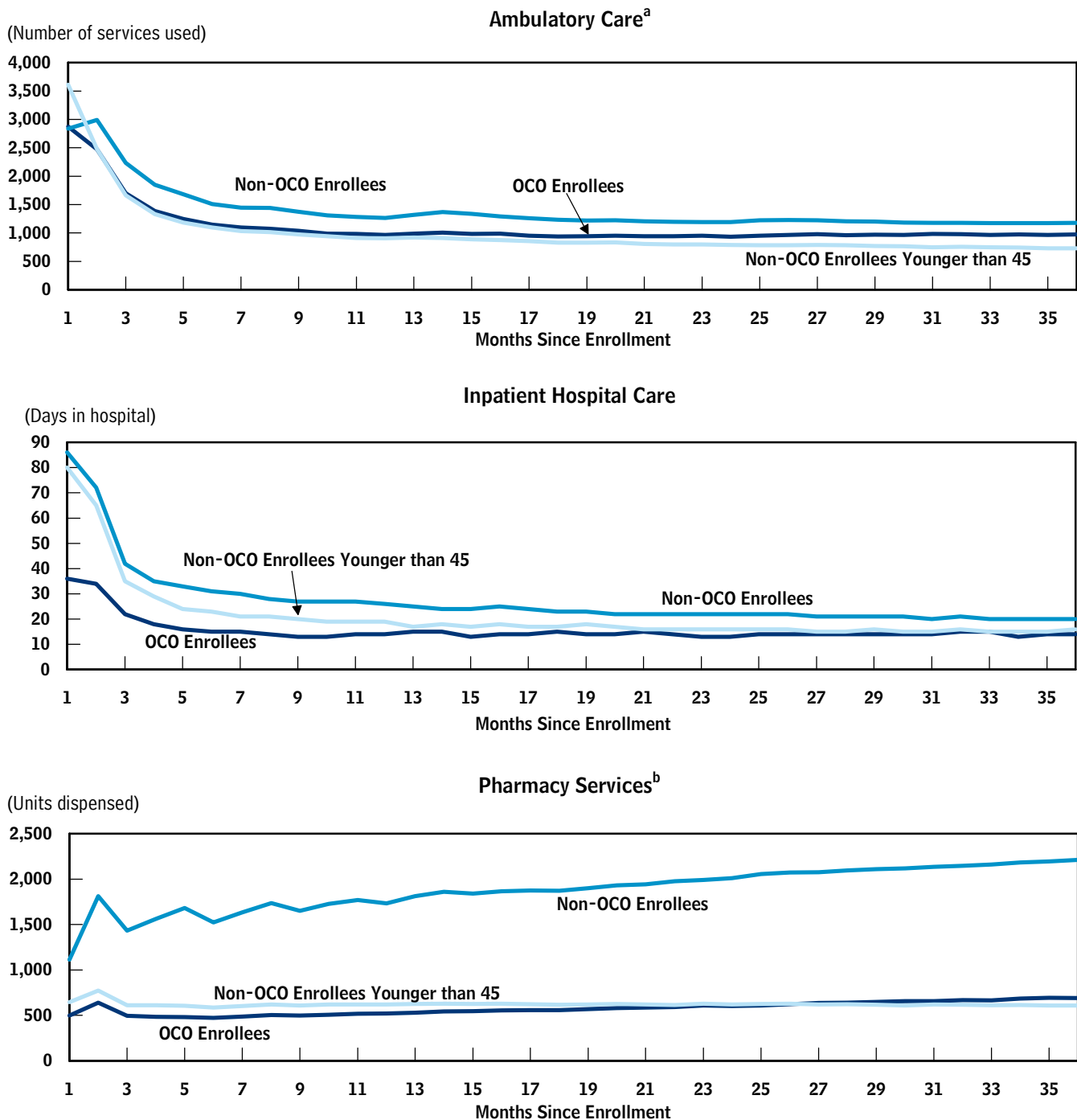
Use of Services by Veterans of Overseas Contingency Operations

Use of services by OCO veterans is substantially lower than for enrollees overall and is generally similar to or lower than that for non-OCO enrollees who are under the age of 45 (see Figure B-2). OCO veterans are likely to be younger than the overall enrollee population, and healthier, because they have not developed age-related conditions, such as diabetes and heart conditions. Nearly 70 percent of OCO veterans are under the age of 45, and all but 1 percent of the rest are under the age of 60. By contrast, about 15 percent of enrollees in the overall VA population are under the age of 45, 40 percent are 45 to 64 years of age, and 45 percent are 65 or older.

OCO veterans' pattern of use is similar to that shown by non-OCO enrollees. Use of ambulatory and inpatient hospital services for OCO veterans declines steadily after enrollment. By the second year, the use of both types of services drops to one-third of the initial rate. Most ambulatory care services follow a similar pattern, with one notable exception: Outpatient psychiatric visits hold steady at about 110 per month for every 1,000 enrollees through three years after enrollment. Enrollees' use of pharmacy services, by contrast, spikes soon after enrollment and then increases steadily for the next few years.

Figure B-2.

Use of VA's Health Care Services by OCO and Recent Non-OCO Enrollees, by Months Since Enrollment



Source: Congressional Budget Office based on data from the Department of Veterans Affairs (VA).

Note: Overseas contingency operations (OCO) include current military operations in Iraq and Afghanistan and related activities.

a. Includes the number of outpatient visits and other services, such as radiology and pathology services.

b. Includes the dispensing of pharmaceuticals, over-the-counter drugs, and related supplies.